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RELIGION, EMOTION, AND SPIRITUALITY IN AMERICAN HOSPITAL CHILDBIRTH

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RELIGION, EMOTION, AND SPIRITUALITY IN AMERICAN HOSPITAL CHILDBIRTH

by

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Dedication

To my incredibly supportive family: Daddy, Malcolm, Molly, Anneke, Libby, Harold, Sophia, and especially my mother, who gave birth so gracefully six times. I owe you everything.

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This project would not have been possible without the enthusiastic support of the faculty at the Institute for the Medical Humanities: my gratitude is boundless. My mentor, Jason Glenn has been a particular inspiration. I would also like to thank Amy Gentry, my constant companion, motivation, and editorial guru throughout this process. I am deeply grateful for the patients and providers who generously allowed themselves to be interviewed for this project. Finally, I would like to thank Robbie Davis-Floyd who has been a mentor and a champion of my research in childbirth for a decade.

Religion, Emotion, and Spirituality in American Hospital Childbirth

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Abstract: This project uses the theoretical lenses of the medical humanities to contextualize 48 interviews that I conducted with providers and patients who labor in hospital settings. Selecting for women and providers who view spirituality or religion as important components of hospital birth, these interviews provide a unique perspective. Focusing on the meanings of the birth process and its spiritual significance in the narratives provided by subjects, the interviews suggest the possibility for providers and patients to view birth in the hospital as simultaneously a spiritually and religiously significant life-cycle event, and a medical event. Examining these interviews, a paradox emerges. On the one hand, providers and patients often experience hospital birth as a spiritually or religiously significant event. As obstetrician Samantha Percival described: "It's a very . . . almost sacred time to be allowed to watch. Kind of like, I would imagine from a worldly sense, a star being born." At the same time, in the discourse surrounding hospital birth, discussions of spirituality or religion are consistently marginalized.

By focusing on the ritual and symbolic practices that pervade hospital birth, and on the narrative, metaphorical, and structural constraints that hospital-based care places on both providers and patients, this project aims to lend understanding to this paradox. I also hope to provide some practical suggestions, both narrative and structural, of ways in which providers and patients can work to facilitate an experience of birth as sacred in whichever location it occurs.

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Introduction

Samantha Percival is an obstetrician and a mother of two who is currently practicing in a mid-sized city, the progressive center of a large conservative state. Percival's practice, which she founded and owns, offers the city's only hospital-based midwifery service. Simultaneously focusing on women's empowerment and evidence based medicine, Percival's practice is well known in her city for being a place that provides support and guidance to women who view birth as more than just a technical or medical event. The practice provides a home for women and providers who value the importance of birth as both a biological and a life-cycle event; something deeply physical, and at the same time profoundly spiritual. The physicians and midwives in her practice also care for many women for whom spirituality is inseparable from a codified system of religious beliefs.

This hospital-based system, integrating midwifery and obstetric care, where patients and providers value both the medical and spiritual elements of birth, was uncharted territory in her city—so much so that the providers in her practice refer to it as, "the experiment." But the demand for this integrated type of care has been huge. Percival put it this way: "Two years into 'the experiment' . . . we are busting at the seams."[1] Therefore (like most of the physicians I interviewed) quite busy, Percival was on call when she invited me to interview her in the spacious, atrium-like cafeteria of the hospital where she works. She described:

> *Some people view birth in a very medical sense and they actually separate off that religious or spiritual component. But I think within our practice there is such a*

[1] Samantha Percival [pseudo.], interview by author, audio recording, 13 June 2010.

> *mindfulness of the women. We [both providers and patients] care about the process of birth, about being true to self, and the power of that process. The gift that you give to your child as well as the gift that you give to yourself in strength; and in a sense of appreciation of what that accomplishment means for one as an individual. That does, at some level, come back to feeding your own spirit: how do we view ourselves as individuals, and how do we view the power of bringing another life into this world, which has its own spirit.*
>
> *I think that gets very intertwined into some of the funny politics of medicine: How much, as women, do we have power over in that decision-making process of giving birth and how much do we become powerless in that process? . . . That opportunity to have some component of spirituality in the birth process can be completely usurped, unfortunately.*

The idea that childbirth is not simply a biological process, but also a spiritually and religiously significant life-cycle event is not new. Early 20th century medical anthropologists describe an intimate association between birth and religion in non-Western cultures. In the West, medical historians have similarly described the importance of religion to the practice of midwifery in the early-modern period, as well as religion's relevance to turn-of-the century obstetric debates.[2]

Even after the medicalization of birth, and its concomitant shift from home to hospital, when this connection became less obvious, minority voices continued to emphasize the importance of spirituality and religion to birth. For example, in 1944, it was an obstetrician, Grantley Dick-Reed, who helped usher in the natural childbirth movement with his publication of *Childbirth Without Fear*.[3] In 1975, Ina May Gaskin, sometimes known as the midwife of the contemporary American midwifery movement, wrote a book called *Spiritual Midwifery,* referring to "the sacrament of birth," and

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[2] James Frazer, *The Golden Bough: A Study in Magic and Religion*. (New York NY: Simon and Schuster, 1900); Claude Levi-Strauss, *Structural Anthropology* (New York, NY: Basic Books, 1963); Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750 to 1950* (New York, NY: Oxford University Press, 1986); William Osler, *Man's Redemption of Man: An Address Delivered at the University of Edinburgh in July, 1910* (New York, NY: P. B. Hoeber Inc, 1937).

[3] Grantly Dick-Read, *Childbirth Without Fear: The Principles and Practice of Natural Childbirth*, 4th ed. (London, UK: Pinter and Martin, 2004).

opining, "the knowledge that each and every birth is a spiritual experience has been forgotten by too many people in the world today, especially in countries with high levels of technology."[4]

Still, in 2010, 35 years after *Spiritual Midwifery,* and over 60 years into the natural childbirth movement, a hospital-based practice that emphasizes the importance of birth as both a biological and spiritual event is still considered an "experiment." While spirituality and religion are commonly accepted to be critical elements of home birth, hospital-based birth with either a spiritual or religious focus remains enigmatic. Since the 1970's, a pervasive focus on home-birth as the exclusive domain of birth spirituality and the direct-entry midwifery as its unitary guardian, has unintentionally marginalized the majority of American women. Despite a great deal of home-birth advocacy, over 99.5% of American women currently deliver in hospitals, under the supervision of obstetricians, nurses, and, less commonly, nurse-midwives. However, as Percival's "busting at the seams" practice suggests, hospital-based care that emphasizes the spiritual aspects of birth is a priority for many patients.

This project will use the theoretical lenses of the medical humanities to contextualize 48 interviews that I conducted with providers and patients who labor in hospital settings. Selecting for women and providers who view spirituality or religion as important components of hospital birth, these interviews provide a unique perspective. Ranging from 1-2.5 hours, and focusing on narratives, the interviews suggest the possibility for providers and patients to view birth in the hospital as simultaneously a spiritually and religiously significant life-cycle event, and a medical event. Examining these interviews, a paradox emerges. On the one hand, providers and patients often

[4] Ina May Gaskin, *Spiritual Midwifery*, 3rd ed. (Summertown TN: Book Publishing, 1990).

experience hospital birth as a spiritually or religiously significant event. As Percival described: "It's a very . . . almost sacred time to be allowed to watch. Kind of like, I would imagine from a worldly sense, a star being born." At the same time, in the discourse surrounding hospital birth, discussions of spirituality or religion are consistently marginalized.

My project examines this paradox by focusing on the ritual and symbolic practices that pervade hospital birth, and on the narrative, metaphorical, and structural constraints that hospital-based care places on both providers and patients. In addition, it provides some practical suggestions, both narrative and structural, of ways in which providers and patients can work to facilitate an experience of birth as sacred in the full spectrum of locations.

BACKGROUND

Non-Western and, more recently, Western birth practices have been the focus of academic investigations across a diverse range of fields in the social sciences and humanities. This has been particularly true in the past forty years. Medical historians have paid particular attention to the *fin du siècle* transition in Western birth from homes to hospitals and from mostly women midwives to mostly men physicians. These studies have produced a variety of perspectives, characterizing this transition variously in terms of medical progress, patriarchal oppression, and more recently in the context of various forms of Western feminism.[5] Particularly since the feminist movements of the mid-

[5] Deborah Kuhn McGregor, *From Midwives to Medicine: The Birth of American Gynecology* (New Brunswick, NJ: Rutgers University Press, 1998); Harvey Graham, *Eternal Eve* (London, UK: Heinemann, 1950); Leavitt; Barbara Ehrenreich, *Witches, Midwives and Nurses: A History of Women Healers* (London, UK: Compendium, 1974); Diana Scully, *Men Who Control Women's Health: The Miseducation of Obstetrician-Gynecologists* (New York, NY: Teachers College Press, 1994); and Jane Donegan, *Women and Men Midwives: Medicine, Morality, and Misogyny in Early America* (Westport, CT: Greenwood Press, 1978).

twentieth century, cultural anthropologists and sociologists have taken a particularly strong role in investigating Western childbirth practices. Many of these scholars situate obstetrics and gynecology in the context of a more generalized critique of authoritative institutional practices, problematizing the efficacy of many technological interventions common to Western childbirth, and framing American childbirth as part of a series of dehumanizing ritual practices designed to inculcate women and their families with the problematic values of American society.[6] This body of literature typically frames midwife-attended homebirth as the appropriate alternative to the dehumanizing experience of hospital birth and the only possibility for spiritually sensitive care .

The possibility for spiritually fulfilling birth attended by physicians in American hospitals has not been rigorously explored in existing literature, although some religious studies scholars, anthropologists, and sociologists have looked at religion in birth. Significantly, recent strides have been made in nursing research. Obstetric nurse Lynn Clark Callister has examined the spiritual and religious aspects of birth stories and suggested them as a legitimate nursing intervention.[7] However, in terms of academic research from the social sciences and humanities, where one might expect a great deal of research into religion and spirituality in Western birth, little scholarship exists. A diverse range of fields consistently emphasize the importance of birth as a transition rite, while paradoxically neglecting the spiritual aspects of birth in Western cultures. Alphia

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[6] Nancy Shaw, *Forced Labor: Maternity Care in the United States* (New York, NY: Pergamon Press, 1974); and Robbie Davis-Floyd, *Birth as an American Rite of Passage* (Berkeley and Los Angeles, CA: University of California Press, 1992).

[7] Lynn Clark Callister, Sonia Semenic, and Joyce Cameron Foster, "Cultural and Spiritual Meanings of Childbirth: Orthodox Jewish and Mormon Women," *Journal of Holistic Nursing* 17, no. 3 (September 1, 1999): 280-295; Lynn Clark Callister, "Giving birth: The Voices of Russian women," *MCN: The American Journal of Maternal/Child Nursing* 32, no. 1 (2007): 18; Callister, "Making Meaning: Women's Birth Narratives," *Journal of Obstetric, Gynecologic, and Neonatal Nursing* 33, no. 4 (August 2004): 508-518.

Possamai-Inesedy points to a "silence of spirituality within sociology of childbirth,"[8] suggesting that sociology specifically neglects the spiritual aspects of childbirth. Carmen Lindhares describes research on spirituality as in its infancy, and research into spirituality and birth as "embryonic."[9] Sharon Moloney suggests the neglect is pervasive in anthropology as well, writing:

> Across a range of cultures and eras, menarche, menstruation and birth have been recognized as spiritual phenomena of great personal, social and cosmological significance. In Western industrialized societies, however, these uniquely female experiences seem to have been drained of their spirituality. They are commonly seen as medical concerns, dubious processes requiring surveillance and control.[10]

Several explanations have been posited for this relative inattention to spirituality in Western hospital childbirth both from clinicians and academics. Moloney suggests that the dearth of focus on spirituality in American hospital childbirth is due to a removal of the spiritual aspects of birth. In other words, the research on spirituality in birth does not exist because birth has been intentionally biologized, desacralized, and as she puts it, "drained" of spirituality.

Cultural anthropologists have examined childbirth and explored spiritual and magical elements of so-called "primitive" birth. [11] Meanwhile, extensive exploration of American hospital birth has focused mostly on the dehumanizing aspects of American birth practices, with little attention to the ways in which spiritual or religious practices can enhance the hospital-birth experience. Perhaps this lack of attention stems from the

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[8] Alphia Possamai-Inesedy, "The Silence of Spirituality within Sociology of Childbirth: Epistemological and Methodological Considerations," *Australian Religion Studies Review* 22, no. 2 (January 30, 2009), 137-160.

[9] Sharon Moloney, "Birth as a Spiritual Initiation: Australian Women's Experiences of Transformation," *Australian Religion Studies Review* 22, no. 2 (October 14, 2008): 190-213.

[10] Ibid., 191.

[11] James Frazer, *The Golden Bough: A Study in Magic and Religion* (New York, NY: Simon and Schuster, 1900); and Claude Levi-Strauss, *Structural Anthropology* (New York, NY: Basic Books, 1963).

fact that many prominent researchers from a variety of backgrounds, both lay and academic, have argued for a return to home-based midwifery care as the best or even only possibility for spirituality and emotionally fulfilling birth.[12] Researchers sometimes malign the attempts of hospitals to offer more homelike care as mere cosmetic changes that do not adequately address the spiritual and emotional needs of birthing women.[13]

It is often taken for granted that spirituality is an important part of midwifery practice, particularly in home-birth midwifery.[14] Indeed, Ina May Gaskin's famous book *Spiritual Midwifery* remains required reading for midwifery certification by the North American Registry of Midwives (NARM). Home-birth practitioners are expected to pay heed to the significant spiritual elements of birth to an extent that is unthinkable in medical education. But to offer home birth as the only potentially successful way to incorporate the spiritual and emotional needs of pregnant women into maternity care invites at least two damaging consequences.

First, from a practical statistical standpoint, this path neglects the majority of birthing women, in addition to particular groups of high-risk women for whom attention to spirituality might be particularly critical. This is particularly troubling considering both the percentage of American births that take place in hospitals and the particular

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[12] Suzanne Arms, *Immaculate Deception: A New Look at Women and Childbirth in America* (New York, NY: Bantam Books, 1977); Raymond DeVries, *Making Midwives Legal* (Columbus, OH: Ohio State University Press, 1996); and Henci Goer, *The Thinking Woman's Guide to a Better Birth*, (New York, NY: Berkley Pub. Group, 1999).

[13] Diana Mason, *Policy and Politics in Nursing and Health Care*, 5th ed. (St. Louis, MO: Elsevier, 2007); Raymond DeVries, Helga Salvesen, Therese Wiegers, and A. Susan Williams, "What (and Why) Do Women Want? The Desires of Women and the Design of Maternity Care," in *Birth By Design: Pregnancy, Maternity Care, and Midwifery in North America and Europe,* ed. Raymond De Vries, Edwin van Teijlingen, and Sirpa Wrede (New York, NY: Routledge, 2001), 243–266; and Sarah Buckley and Ina May Gaskin, *Gentle Birth, Gentle Mothering: A Doctor's Guide to Natural Childbirth and Gentle Early Parenting Choices* (Berkeley, CA: Celestial Arts, 2009).

[14] Pamela Pamela Klassen, *Blessed Events: Religion and Home Birth in America* (Princeton, NJ: Princeton University Press, 2001).

importance of spirituality to women with high-risk or complicated pregnancies for whom home birth is not feasible.[15] Furthermore, home may not be a safe environment for some women, for example in instances of domestic abuse.[16] In her study of spirituality in home birth, Religious Studies scholar Pamela Klassen suggests that women, "are not content to consider birth and maternity either irredeemably sullied by long-held patriarchal projections or hopelessly disenchanted by medical procedure."[17] The same argument can and should be made for hospital birth.

Second, and perhaps less commonly discussed, focusing childbirth debates around the legitimacy of home birth often creates fierce antagonism between birth advocates and physicians by inappropriately implying that doctors and nurses cannot provide, advocate for, or educate others in humane, spiritually and emotionally attentive care for their patients. In particular, there is a dearth of scholarly work that engages the social and cultural influences on obstetric practice in a way that speaks to physicians. Several sociologists and anthropologists who study birth have questioned why, after over forty years of research and advocacy, a great deal of American hospital-based childbirth remains emotionally and spiritually unsatisfying for many women and their families.[18] The lack of change in American hospitals may stem, at least partly, from the rhetorical style embraced by many childbirth researchers, which tends to alienate physicians. Additionally, harsh criticism of medical technology (and of the doctors themselves)

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[15] Linda Dunn and Marvin Mitchell Shelton, "Spiritual Well-Being, Anxiety, and Depression in Antepartal Women on Bedrest," *Issues in Mental Health Nursing* 28, no. 11 (November 2007): 1235-1246; Sheri Price et al., "The Spiritual Experience of High-Risk Pregnancy," *Journal of Obstetric, Gynecologic, and Neonatal Nursing* 36, no. 1 (February 2007): 63-70.

[16] Anne Drapkin Lyerly, "Shame, Gender, Birth," *Hypatia* 21, no. 1 (2006): 101-118.

[17] Klassen, *Blessed Events: Religion and Home Birth in America*, xii.

[18] Wendy Simonds and Barbara Rothman, *Laboring on: Birth in Transition in the United States* (New York, NY: Routledge, 2007).

apparent in many studies of American birth sometimes neglects the critical importance of access to such technology (and skilled labor) both for Western women[19] and women in the developing world.[20] Furthermore, changing demographics in the field of obstetrics and gynecology suggest that the field will soon be dominated by female providers. Some of these women self-identify as feminists,[21] and some chose obstetrics and gynecology specifically because the field offers an important way to empower women.[22] Engaging these providers in dialogue demands a rhetorical style that acknowledges their commitment to and respect for the women in their care.

RELEVANCE

There are multiple points of intersection between spirituality, religion, and maternity care in American hospitals. At a very concrete level, maternity care providers are increasingly expected to care respectfully for women from religious backgrounds other than their own. For some of these women, this will mean that acknowledgement of birth as a religious experience necessitates particular tasks on the part of the health care team. Percival described:

> *We'll have patients who are Muslim who don't want any men in the room, or where the father plays more or less of a role. Also [we have] patients who are Jewish who will come in to the office to do a circumcision as close to day 8 as possible and bring the wine and read from the torah. And again [we try hard to] make people feel like they can include that in the process.*

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[19] Lyerly, "Shame, Gender, Birth."
[20] Lewis Wall, "The Anthropologist as Obstetrician: Childbirth Observed and Childbirth Experienced," *Anthropology Today* 11, no. 6 (December 1995): 12–15.
[21] Lyerly, "Shame, Gender, Birth"; Barbara Rothman, "Now You Can Choose!" in *Revisioning Gender*, ed. Myra Ferree, Judith Lorber, and Beth Hess (Walnut Creek, CA: Alta Mira Press, 1998), 399-415; and Barbara Love, *Feminists Who Changed America, 1963-1975* (Urbana, IL: University of Illinois Press, 2006), 40.
[22] Boston Women's Health Book Collective, *Our Bodies, Ourselves: A New Edition for a New Era*, 35th ed. (New York, NY: Simon and Schuster, 2005).

Many of my interview subjects intuitively gravitated towards this type of understanding of the intersection between birth and religion or spirituality. Rima Shartzcova, a labor and delivery nurse at a large suburban Catholic hospital, immediately pointed out the crucifixes on the wall in every delivery room, saying that some patients took them down, while Alyssa Clarkson, a certified nurse-midwife at a large University Medical Center told me about struggling to be respectful of her Orthodox Jewish clients whose husbands could not touch them during labor due to halakhic restrictions.[23] Similarly, both Austin Franklin, the chief resident in obstetrics at a large army medical center and Mark Blake, an attending at the same hospital, informed me about the commonly cited issue of conservative Muslim women who do not want male birth attendants. For overtly religious women, lack of acknowledgement of birth as a religious event in the life of a woman can lead to feelings of shame and even trauma.

But beyond these obvious intersections of religion and maternity care involving ritual restrictions or specific tasks that providers must perform in order to maintain cultural sensitivity, childbirth is a profoundly spiritual experience for many women, including those who are non-religious. Callister's ethnographic research suggests that women from a diverse array of backgrounds consider birth to be a "transcendent, emotional and spiritual experience."[24] Even for women who conform to strict traditional religious belief systems, respect for spirituality in maternity care and birth encompasses more than simply acknowledging restrictions like those mentioned above. Callister writes

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[23] Rima Shartzcova [pseudo.], interview by author, audio recording, 19 February 2010; Austin Franklin [pseudo.], interview by author, audio recording, 25 May 2010; and Mark Blake [pseudo.], interview by author, audio recording, 25 May 2010.

[24] Callister, Semenic, and Foster, "Cultural and Spiritual Meanings of Childbirth," 288.

in her study on Mormon and Orthodox Jewish women, "Giving birth was a spiritually moving and sacred experience beyond simply being an expression of a religious perspective."[25]

METHODS

An interdisciplinary perspective from the medical humanities is in many respects ideally suited for an exploration of emotion and spirituality in hospital childbirth. The study of the humanities enjoys a hallowed position in the profession of medicine, both in its historical and contemporary forms. Though it is plagued by perennial issues of underfunding and curricular marginalization, the humanities continue to function for many physicians as a vital foil to the reductivist tendencies of technologically driven modern medicine. And when physicians emphasize the emotional health and well being of patients and, to paraphrase theologian Paul Ramsey, strive to care for their patients "as people," they are often said to be practicing "humanistic" medicine. Similarly, Davis-Floyd suggests the "humanistic model" as one framework for contextualizing medical practice, in alternative to the technocratic model she criticizes.[26] The word *humanist* in these contexts clearly refers to an abiding respect for the welfare of humans, but it is not entirely divorced from its other definition, one who studies the humanities. Indeed, it is sometimes taken for granted, particularly in circles of physicians, that one flows naturally from the other. And the study of the humanities, in its various forms, has long served this function for many physicians.

Before the Second World War, physicians dominated the field of the history of medicine, and understanding the history of their profession continues to be an important

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[25] Ibid.

[26] Robbie Davis-Floyd, *From Doctor to Healer: The Transformative Journey* (New Brunswick NJ: Rutgers University Press, 1998).

avocation for many contemporary physicians. Unlike most academic historians, physicians often view the history of medicine both as a way to memorialize and connect physicians with their past, and as a way of instilling humanistic principles in their own practices and those of their students. The physician history of medicine society, the American Osler Society, for example, has a mission "to continually place before the profession a reminder of the high principles of life and humanism . . . and to introduce these things to those entering the profession."[27] In addition to history, literature has also played a prominent role in medicine both historically and in modern practice as a way of humanizing physicians. Turn-of-the-century physicians like William Osler recommended the study of classical literature to medical students as an important adjunct to medical practice. More recently, an attention to narrative in medical practice has emerged as an independent field of study closely connected with humanistic medical education and practice. First, there has been an emphasis on literature as a way to inform the moral imaginations of physicians. This concept has reinvigorated the study of literature as an official part of many medical curricula through the discipline of literature and medicine. Second, in a more radical turn to narrative, authors have suggested the critical function of stories in medical practice, arguing that witnessing narratives is a moral act,[28] that constructing narratives endows illness with meaning,[29] and that narrative work constitutes much of medical practice.[30]

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[27] "American Osler Society, Founded 1970," Accessed March 2012. http://www.americanosler.org/historypage.htm.

[28] Arthur Frank, *The Wounded Storyteller: Body, Illness, and Ethics*, Pbk. ed. (Chicago, IL: University of Chicago Press, 1997).

[29] Frank, *The Wounded Storyteller: Body, Illness, and Ethics*; Arthur Kleinman, *The Illness Narratives Suffering, Healing, and the Human Condition* (New York, NY: Basic Books, 1988).

[30] Kathryn Montgomery Hunter, *Doctors' Stories* (Princeton, NJ: Princeton University Press, 1991); and Rita Charon, *Narrative Medicine: Honoring the Stories of Illness* (Oxford, UK: Oxford University Press, 2006).

Scholarly criticism from bioethics and the social sciences tends to focus on the more scientifically oriented aspects of physician identity, but as the modern professionalism movement has highlighted, physicians have long enjoyed a dual identity as both rational scientists and empathetic healers. True, the physician must wield abstract rational scientific knowledge, but to be successful, she must do so with an empathetic and artful attention to an individual patient. As Osler famously suggested, "The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head." This balance, between heart and head, as Osler puts it, typifies the clinical experience for many physicians.

To use Stephen Toulmin's framework, modern Western medicine embraces twin heritages, drawing heavily on both Enlightenment,[31] modes of thinking, through aspirations towards scientific rigor, and Renaissance humanism, through an attention to the individualized, emotional aspects of patient care. Many physicians and their educators see the study of the humanities as a way to instill empathy and compassion in physician practice. Certainly scientifically based technological competence is necessary to good clinical practice, but alone it is not sufficient. Expert clinicians must twin the Enlightenment-driven goal of applying abstracted scientific expertise to the body with a Renaissance humanist orientation that emphasizes the patient as an individual, demanding attention to emotion and context.

This raises the question of finding a research methodology that hopes to influence medical practice. Because of the twin identities of the physician as both scientist and healer, researchers with a physician audience have two broad possible paths in terms of methodological approach. Some scholars will opt to use positivistically oriented

[31] Toulmin refers to this period as the "seventeenth-century Counter-Renaissance."

methodologies that speak to the identity of the physician as scientist. Many quantitative, and some qualitative research methods in the social sciences take this approach. Alternately, researchers can use methodological approaches from the humanities with an appeal to the physician as humanist. Positivistically oriented approaches that draw heavily on the scripts and vocabulary of the scientific method have the advantage of making an argument in terms of empirical observation of facts, consistency in approach, and, in ideal situations, reproducibility. And some researchers make the argument that, since the medical lexicon is largely a scientific one, academics hoping to influence medical practice must embrace it if they hope to influence medical practice.

The disadvantage of adopting the scientific model is that it is an empirical discourse that intentionally eschews that which cannot be reliably, reproducibly measured. This makes a scientifically oriented methodological approach particularly impoverished for the investigation of a topic like spirituality and emotion in childbirth. Spirituality, by nature, will be highly individualized and variable, and rely extensively on metaphoric and narrative modes of thinking. This project will therefore draw on methodologies that speak to the humanistic heritage of the physician

In addition to relying heavily on theoretical arguments from the medical humanities, this project examines the content of 48 interviews that I conducted with maternity care providers and women who labor in hospitals. I intentionally selected for women who identified spirituality or religion as an important aspect of childbirth and who gave birth in hospitals. I likewise identified maternity care providers who identified spirituality or religion as an important aspect of the hospital-based care they provided.

Maternity care in the hospital is increasingly thought of in terms of the "health care team." In obstetrics and midwifery, this includes a wide range of providers with differing levels of hospital-association, different types of decision-making power,

differing educational backgrounds, and diverse perspectives on spirituality and birth. In an attempt to get a range of diverse perspectives I interviewed physicians, nurse-midwives, nurses, and doulas (non-medical labor-support professionals)[32] who worked in hospitals. Since I wanted to select for women who valued spiritual aspects of birth, and home-birth communities are well known for this kind of emphasis, I contacted local religious communities and the local chapter of the professional doula's association, DONA (Doulas of North America) International. Several of my initial interviews came from a small, progressive Christian church community that included a large number of home-birth mothers. I used chain sampling: patients referred me to providers, and providers to other patients. I also interviewed providers who were professionally involved in dialogue about spirituality in birth and they referred me to colleagues who they believed would be interested. In terms of interviews, obstetricians are a particularly elusive population, particularly so considering that I wanted to talk with providers who overtly viewed birth in spiritual or religious terms.[33] As a result there was a fair amount of regional variation among the obstetricians that I interviewed. In particular, one provider, Kevin Feldman, invited me to visit his hospital in a large, Midwestern city, where I had the privilege of witnessing a beautiful and moving birth he attended. I also interviewed two obstetrics residents and a doula, Rachel Marini, with whom Feldman had worked with for many years. Marini took me to see my first home-birth in a high-rise downtown apartment.

A great deal of my interview process involved collecting narratives. Interviews were structured around two major narratives. First, in my patient interviews, I began by

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[32] Some doulas specialize exclusively in pre-natal and post-partum support of birthing women. I only interviewed doulas who also attended births.

[33] Simonds and Rothman, *Laboring on: Birth in Transition in the United States*.

asking women to tell their birth story or stories. For providers, I began interviews by asking for a vocational narrative. Physicians are asked the question, "Why medicine?" at multiple times over the course of their careers, and this vocational narrative becomes important to their education and practice. Second, I asked interviewees to recount their spiritual or religious background. In addition to these two narratives, which formed the central core of the interviews, I also asked providers to share birth stories. In particular I asked them to describe births that they felt had particularly spiritual or religious components. At the recommendation of two separate obstetricians, I also asked providers to describe births that were challenging for them emotionally or spiritually and I asked if they remembered their first delivery.

NARRATIVE

This project relies heavily on narrative examples from patients and providers who succeeded in sacralizing their experience of birth in hospital environments. I rely on a narrative methodology foremost because I am convinced by the argument, common in religious studies, that narrative, with its attendant metaphoric and descriptive elements, provides the best framework for examining spiritual and religious experience. This choice also hinges on the dearth of existing positive stories in which aspiring maternity-care providers might view themselves as characters, and contextualize their experience. Medical anthropology and sociology of birth provide a litany of negative role models for young physicians and nurses, but few positive ones. The last fifty years of scholarship from the social sciences and humanities constitutes a major deconstruction of traditional narratives about virtuous physicians. And while this project has been vital to medical reform, it also has a distressing unintended negative consequence: it leaves contemporary physicians story-less. This lack of positive narratives is not an insignificant problem, but

one that has drastic consequences for the cultivation of virtuous medical practice and spiritually sensitive patient care. Philosopher Alasdair McIntyre has written about the importance of a narrative tradition to the cultivation of virtuous practice.[34] He writes: "I can only answer the question 'What am I to do?' if I can answer the prior question 'Of what story or stories do I find myself a part?'[35] For aspiring doctors, the deconstruction of medical hagiography and of a social narrative in which medicine functions as a reification of scientific progress, problematizes the cultivation of virtuous practice. If MacIntyre is right, young doctors cannot adequately answer the question 'What am I to do?' when the traditional stories that they are a part of are no longer viable, or if those stories cast them as villains. As McIntyre writes, "Deprive children of stories and you leave them unscripted, anxious stutterers in their actions as in their words." [36] Such is the case among contemporary obstetric and nursing trainees. The positivist hagiographies that characterize mid-century narratives about obstetrics are surely bankrupt, but if we are to be successful in reforming obstetric practice, we must do more than deconstruct these stories. We must also present viable alternatives. I hope that this project will be just the beginning of a new story by which young medical professionals can begin to cultivate articulate speech and action, and sustainable virtuous practice.

In obstetric and hospital midwifery practice the condescension towards the subjective or spiritual manifests itself, in the embracing of very specific narrative forms. Attention to the narratives allowed by traditional obstetric forms helps explain the conspicuous lack of focus on spiritual and religious aspects of childbirth in Western

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[34] Alasdair MacIntyre, *After Virtue: A Study in Moral Theory*, 2nd ed. (Notre Dame, IN: University of Notre Dame Press, 1984).
[35] MacIntyre, 216.
[36] Ibid.

hospitals. Traditional obstetric narratives like the case history and patient chart embrace a rationalist epistemology based on verifiable empirical observation, which necessarily rejects concepts that can be viewed as metaphysical or supernatural. Examining the ways traditional obstetrics forms elide the subjective and spiritual aspects of birth can help explain why spirituality is often overlooked in research about hospital childbirth: the traditional narrative forms available in hospital-based obstetrics practices are *intentionally* constructed to eschew the subjective and affective elements necessary to narratives of spirituality. This means that even when health care workers recognize spirituality or religion as a vital aspect of birth, they cannot articulate these beliefs using traditional obstetric narratives. For example, one nurse, Parker Robinson said in our interview, "moms go through birth as an object [not realizing] that they are a manifestation of the feminine divine."[37] A sentiment like this one is difficult to articulate in a climate that emphasizes objective systems of knowledge and cannot be adequately expressed in a case history or patient chart.

My own membership as part of the medical establishment probably placed some constraints on the type of story my interview subjects told me. Robinson for example, who has a masters in theology in Sufi studies, and spent a great deal of time studying eastern religion with a guru in India, stopped herself during our interview to check in with me. "I always talk in energetic language," she said, "is that okay?" If interview subjects felt restricted in the kinds of narratives they could tell in interviews, the problem is exacerbated to a much greater degree in hospital obstetrics practice where concepts like "the feminine divine," and "energetic language," seemingly have no place.

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[37] Parker Robinson [pseudo.], interview by author, audio recording, 15 June 2010.

Contextualizing the case report as a narrative form, or genre, with restricted conventions and forms can help explain why spirituality seems to go missing in hospital-based obstetric care. Looking closely at the ways physicians and nurses must configure their experiences of birth within specific genres can better our understanding of the meaning of birth for practitioners. While these forms are highly useful in the business of diagnosis and treatment, they intentionally reduce the importance of the subjective, affective, and spiritual dimensions of illness, and there is little variation in their application.

The idea, common in social sciences, that American hospital childbirth is hopelessly devoid of spiritual meaning, stems in part from the conventions of medical genres. The case history, case report, and patient chart, simply have no space for spiritual content. As my interviews evince, this does not mean, as many researchers have previously assumed, that providers do not identify spiritual and religious aspects of birth, but it does mean that they will be forced to resort to alternative narrative forms if they hope to articulate spiritual content.

Narrative modes of inquiry are well suited to explorations of religious and spiritual experience. Childbirth in American hospitals remains a significant spiritual event for health-care providers and their patients, and examining non-traditional or alternative obstetric narrative forms that emphasize spirituality is an appropriate method for analyzing birth as a spiritual or religious experience. Sociologist David Yamane has argued that narrative examinations are the best mode of inquiry into religious experience, suggesting that phenomenological approaches are inadequate for approaching the highly representational and narratively imbedded nature of religious experience. He writes:

> When we study religious experience we cannot study 'experiencing'--religious experience in real time and its physical, mental, and emotional constituents--and

> therefore must study retrospective accounts--linguistic representations--of religious experiences. It is in the nature of experiencing and its linguistic expression that these two are loosely coupled and therefore we do not study phenomenological descriptions of experiences but how an experience is made meaningful.[38]

Yamane suggests that it is through the process of narration that specific life events are made religiously meaningful. And in the specific case of childbirth, Callister reminds us that the meaning that women make of their birth experience is highly dependent on the birth stories they tell. Through stories, women experience "the opportunity for integration of a pivotal event into the framework of life."[39] If we are to examine instances in which childbirth as it takes place in Western hospitals is made spiritually and religiously meaningful, or suggest ways in which physicians can avoid evoking "spiritual distress" in their patients by ignoring the spiritual aspects of birth, we will have to critically examine the kind of narratives that providers and their patients tell in order to make a space for new ones.

The story a provider tells about a birth will inevitably influence the meaning the patient makes of her birth experiences. For this reason a narrative approach that underscores alternative narrative forms on the provider side is useful to patients as well as providers. Since the physician or midwife is in a position of cultural authority, the narrative she tells about her patient's birth will not only help frame the meaning she makes of the experience as a health care provider, but it will also greatly impact the story a woman will tell about her own childbirth experience, and consequently the meaning she makes from that experience.

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[38] David Yamane, "Narrative and Religious Experience," *Sociology of Religion* 61, no. 2 (Summer 2000): 173.
[39] Moloney, "Birth as a Spiritual Initiation," 191.

CHAPTER DESCRIPTIONS

This dissertation is in three sections. Section 1 (Chapters 1 and 2) is largely theoretical and examines the marginalization of the sacred in hospital birth, first from a clinical and second from a religious perspective. Section 2 (Chapters 3 and 4) focuses on interviews with maternity-care providers, and Section 3 (Chapters 5 and 6) focuses on interviews with patients.

Chapter 1 lays groundwork for understanding medical care in general, and hospital-based maternity care in particular, as ritually and symbolically laden practices. The reluctance of many hospital-based practitioners and patients to engage in a discourse about birth as a practice laden with ritual and symbolic meaning presents a challenge to infusing birth with religious or spiritual meaning. This chapter will begin by demonstrating the historical and contemporary importance of spirituality and religion in childbirth. I argue for the importance of symbolic meaning in childbirth in the spiritual lives of women, examining contemporary and historical sources. I examine three themes in American obstetrics that have contributed to a marginalization of spirituality in American medical practice: the Enlightenment hope for timeless, decontextualized truth, the primacy of the observable, and medicine's desire to represent a post-religious, modern ideal. I rely primarily on Toulmin's framework of the Renaissance and Counter-Renaissance, Michel Foucault's discussion of the clinical gaze, and Bruno Latour's concept of the modern constitution. Medicine inherits many of the Enlightenment hopes for perfect decontextualized truths, manifesting particularly in its emphasis on the visible. This inheritance results in a devaluing of non-visible and arational aspects of medical care and a marginalization of spirituality in medical practice in general, and obstetrics in particular.

Chapter 2 examines ways in which religion problematizes discussions of the sacred in birth. As an embodied, physical, and distinctly feminine experience, childbirth has few overtly religious rituals or rites associated with it in major Western religious systems. In Christianity and Judaism in particular, where Abrahamic monotheism manifests itself as a belief in a single deity, often represented as male, feminine spirituality often appears only on the periphery. Furthermore, the historical legacy of Christianity contributes to a devaluation of the body in general, and female embodiment, which is often associated with sexual shame, in particular. This, along with a traditional dichotomy in religious studies between religion and magic leaves little space for discussions of an authentic spirituality of birth from the religious studies perspective.

Chapter 3 focuses on the narratives that constitute medical practice from the provider's perspective. Often limited by the restrictive narrative forms routinely used in medical practice (i.e. case reports, patient charts, etc.), hospital-based maternity care providers are not typically given the opportunity to tell narratives of the deliveries they attend in a way that emphasizes emotion or spirituality. My interviews allowed physicians to narrate their experiences of birth as spiritually or religiously significant in a way that is rarely invited in the traditional narrative structures employed in the medical encounter. These stories employed a novel narrative genre, "the clinical tale."

Oliver Sacks coined the term *clinical tales* to describe his narratives of patients with profound neurological illness. The clinical tale, as he describes it, is a narrative genre very distinct from the traditional case history. The clinical tale frees the narrator to describe both the poetic and dramatic elements of an illness, and its biomedical

elements.[40] Alternative genres like the clinical tale allow providers to describe significant birth experiences as both spiritual and clinical.

Chapter 4 examines the paradox of power and surrender in spirituality and birth. The two major tools provided to women who choose hospital birth, doula assistance and birth plans, sometimes create tension in the delivery room. Though they are intended to empower women in birth, birth plans can sometimes create a dynamic where patients have inappropriate expectations of being able to control birth, a very out-of-control process. As one doula I interviewed suggested, "make a birth plan and watch God laugh." Similarly, when a doula is forced into an antagonistic role with respect to the medical establishment, the opportunities for women to view birth as a spiritually or religiously significant life-cycle event can be impeded rather than facilitated. Many interviewees emphasized the importance of surrender in childbirth as one of its most significant spiritual aspects. Interviewees also emphasized the importance of trust between all those attending a birth in facilitating birth as a spiritually significant event. This included family members, doulas, nurses, midwives, physicians, and the birthing woman.

Chapter 5 focuses on birth stories from patients that blur the home-hospital divide common in midwifery activism. The chapter examines obstetric technology, routine, and place of delivery. There was a wide range of interpretation of obstetric technology, routinized care, and place of delivery in the birth stories I collected. Obstetrician Anne Drapkin Lyerly writes that birth technology can be humanizing in the appropriate context. The stories I collected similarly suggest that rather than obstetric technology per se, it is the impersonal application of such technology that impedes a recognition of birth as a spiritually or religiously significant life-cycle event. Obstetric routine could similarly

[40] Oliver Sacks, "Clinical Tales," *Literature and Medicine* 5 (1986): 16-23.

be experienced positively if it was intended to facilitate a positive birth experience for patients. I also examine the idea of birth territory from a metaphoric perspective where maternity care providers can hold open a metaphorical home-like birth space within a clinical environment.

Chapter 6 looks specifically at narratives from Jewish and Christian women, examining the ways in which they frame their experiences of pain and choice in childbirth. Long characterized as the curse of Eve, these women recontextualize labor pains as empowering, and sometimes-visionary spiritual experiences. Creating a feminine spirituality of birth within the context of a patriarchal religious system is an important moral task. These women use what philosopher Jeffery Stout has called, moral bricolage to sacralize their experiences of birth under monotheistic Western traditions.

The conclusion will focus on a powerful birth story in the form of a five-part poem about stillbirth called, *The Grief Cycle* by one of my interviewees, Eva Jacobs. This poem illustrates how a novel genre of birth story can present a fearless feminine spirituality of birth. Raw, evocative, and emotional, the poem addresses the darker side of female embodiment, putting embodied processes like menstruation, lactation, and birth in an uneasy proximity with death. Jacobs' poem illustrates the potential for novel narrative genres to describe spiritual and religious experiences of birth in a way that sacralizes both positive and negative aspects of feminine embodied power and spirituality.

SECTION I: THEORETICAL CONCERNS

Chapter 1:

The Marginalization of the Sacred in Childbirth: *Childbirth, Medicine, and "the Modern"*[1]

> *The strict, militant, dogmatic medicalization of society, [was made possible] by way of a quasi-religious conversion, and the establishment of a therapeutic clergy.*
>
> -Michel Foucault, *The Birth of the Clinic*, 1963

> *It may be that in time scientists will be able to give such complete proof of the rightness of materialism that . . . the church will be replaced by the clinic; but my close association with the birth of a child has led me to believe that there is a limitation to science and that the extending boundaries of human knowledge have only reached the foothills of omniscience.*
>
> -Grantley Dick-Reed, *Childbirth Without Fear*, 1959

> *You call yourself religious? The modern critique will have a hearty laugh at your expense!*
>
> -Bruno Latour, *We Have Never Been Modern*, 1991

Childbirth is an important life-cycle event. As such it concerns itself with liminality and in many cases with what Rudolph Otto has called the *mysterium tremendum et fascinans,* the awe, fear, and fascination inspired by an encounter with the numinous. Because of its importance as a life-cycle event, its unpredictability, the

[1] Portions of this chapter appeared in an earlier publication. Margaret Wardlaw, "American Medicine as Religious Practice: Care of the Sick as a Sacred Obligation and the Unholy Descent into Secularization," *Journal of Religion and Health* 50, no. 1 (January 2010): 62-74. *The Journal of Religion and Health* is a Springer publication. Permission is granted by Springer to any author seeking to use her own work in a dissertation.

vulnerability it engenders, and its uneasy association with death, birth is inevitably marked by ritual, symbol, and metaphor. Though they are the language of religion, allopathic medical practice has an uneasy relationship with these arational, non-empirical modes of understanding. The consequent absence of focus in American hospital birth on either spirituality, which concerns itself with ultimate or immaterial reality, or religion, the ritual and symbolic systems of faith that mediate access to ultimate reality, is problematic.

This chapter will set up a theoretical context for explaining a recurring tension that I encountered in narrative interviews with hospital based providers and patients. While these patients and providers identified religion and spirituality as vital aspects of American hospital birth, the importance of birth as a significant life-cycle event is not emphasized in literature surrounding hospital-based maternity care. The marginalization of religious and spiritual aspects of hospital birth from both clinical and non-clinical academic spheres demands explanation.

The chapter is in two parts. Part I will explain the marginalization of religion and spirituality in modern medical practice generally and obstetrics specifically. With the medicalization of illness and birth, religious authority over the body was transferred from the church to the medical establishment. Unlike religion, medical practice is an Enlightenment-driven institution that conceives of itself as decidedly modern, and therefore hospital practice offers little space, either in its physical structures or its narrative forms, for a contemplation of the numinous. I identify three trends that contributed to a declining emphasis on religion and spirituality in Western maternity care: a shift from religious to medical authority over the body in Western contexts, the rise of allopathic medical practice as the dominant framework for understanding illness and birth, and the hope of medical practice to embody a post-religious modern ideal. I also

outline the tension in existing social sciences and humanities literature that tends to elevate ritual healing practices in non-Western culture, while simultaneously calling for "secularization" of medicine in the West.

Part II will focus on narratives from anthropology, medical history, and midwifery that overtly address the religious or spiritual elements of birth. Examining these narratives from the perspective of what Bruno Latour has called "the modern constitution" is enlightening. Rather than making a case for the importance of spirituality and religion in maternity care, these narratives instead set up a pre-modern *other* against which allopathic medical practice can view itself as both enlightened and biologized. The chapter concludes by examining the pitfalls of "secularization," arguing instead for an intentional and selective examination of symbolic, ritual, and religious practice in American hospital childbirth. It is hopeless for practitioners to try to purify obstetrics of its ritual function. Rather they should acknowledge the symbolic nature of birth practices in Western and non-Western cultures, rejecting rituals that are harmful from either a psychological or physiological perspective, and embracing those that represent important healing values.

RITUALS, SYMBOLS, RELIGION, AND HEALING

Amidst the milieu of the social movements of the 1960's, a broad critique of early twentieth-century anthropology emerged. This critique suggested that anthropological discourse in the early 20th century had functioned as a way of delimiting a savage *Other* against which Western man could define himself as *modern*. This dichotomy between *savage* and *modern* legitimized harmful colonial practices that attempted to enforce Western cultural hegemony. In terms of healing systems, this dichotomy often manifested itself by characterizing non-Western medicine as collections of irrational and

superstitious folk-beliefs and Western medicine as the enlightened modern application of science to the body. Two major trends in the social sciences and medical humanities emerged out of this critique. First, in the social sciences surrounding medicine, the critique led to a re-valuation of non-Western healing practices, even when such practices could not be proven to have any legitimate physiological function by standard medical criteria. For example, E. Evans-Prichard, in his famous work among the Azande in central north Africa, suggested the social importance of ritual healing practices, even when such practices did not function on any perceivable biological level.[2] In an even bolder move, Levi-Strauss' work surrounding childbirth incantations among the Cuna Indians suggested that ritual practices could effect physiological change, in this case easing an obstructed labor.[3]

Second, at the same time, medical anthropologists began to turn their critical gaze on Western medical practices; unmasking the ritual and social functions of allopathic medical practices that purported to have purely biological motivations. In the anthropology of birth, this was achieved most famously by Robbie Davis-Floyd. Her groundbreaking book, *Birth as an American Rite of Passage,* examined the interventions common in American childbirth from a ritual perspective.[4] Surprised by how many common obstetric interventions controverted clinical evidence, Davis-Floyd examined the function of practices like routine episiotomy and continuous electronic fetal monitoring from a ritual and social perspective. Far from being a purely biological event best monitored and controlled with routine medical interventions, Davis-Floyd's book

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[2] E Evans-Pritchard, *Witchcraft, Oracles, and Magic Among the Azande,* 1937 (Oxford, UK: Clarendon Press, 1976).
[3] Claude Levi-Strauss, *Structural Anthropology* (New York, NY: Basic Books, 1963).
[4] Robbie Davis-Floyd, *Birth as an American Rite of Passage* (Berkeley and Los Angeles, CA: University of California Press, 1992).

argues convincingly that childbirth, even in the American hospital, is a rite of passage marked by technological rituals, and taking place in a culture that values technology as an ultimate good.

Ironically, while major works examining non-Western medical care were increasingly emphasizing the positive role played by ritual in indigenous healing systems, studies of allopathic medicine tended to treat ritual as something that needed to be eliminated. Bioethicist Roy Branson, for example, criticized these ritual functions of medicine, calling for the "secularization of American medicine," which he argued was inappropriately taking on ritual functions and rising to the status of a religion. Branson's 1973 *Hasting Center Studies* paper was an impassioned manifesto and a critique of "the new priesthood" of American physicians who used the religious power of American medicine to define deviance, wield moral authority, and "divide the diseased from the holy."[5] Versus this priesthood, Branson called for democratization and secularization, and he looked forward to the day when, "The patient will approach the physician, not as a supplicant, but as a fellow-citizen."[6]

A double standard emerged out of this literature. While ritual, symbolic, and religious aspects of healing practices were increasingly being taken seriously as an important component of indigenous medical systems, investigations of Western medical practice contextualized such practices as ritual and symbolic infestations that should be eliminated via a "secularization" of allopathic medical practice. Missing from this critique was any serious discussion of the continued importance for ritual and symbolic aspects of healing and birthing practices in the Western world. An inappropriate

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[5] Roy Branson, "The Secularization of American Medicine," *The Hastings Center Studies* 1, no. 2 (1973): 21.
[6] Ibid., 27.

dichotomy persists today, insisting that religion is the appropriate domain for ritual and symbolic practice in contemporary Western culture, while allopathic medicine should work at a purely desacralized, biological level. Mircea Eliade has described this desire to separate the sacred from the physiological in terms of a "modern consciousness." He writes: "For the modern consciousness, a physiological act . . . is in sum only an organic phenomenon . . . But for the primitive, such an act is never simply physiological; it is, or can become, a sacrament, that is, a communion with the sacred."[7] Eliade's insight suggests that the desire for secularization, for the organic phenomenon to be perceived as purely physiological, exists in tension with the modern, post-religious ideal that attends allopathic medical practice.

The idea that medicine should be secularized, that is, divorced from its ritual and symbolic functions, is problematic. Illness, birth, and death are major life-cycle events marked by ritual and religious practices in most cultures. For home-birth midwives, who are less fettered by the obsession with objectivity that attends allopathy, this distinction is less problematic. But for providers and patients who work and give birth in hospitals, the assumption that medicine should attempt to rid itself of ritual, religious, or spiritual concerns creates a great deal of tension. Mark Blake, one of the obstetricians I interviewed put it this way:

> *I believe that it [spirituality and religion] has a place in all care, in all medical care . . . The biopsychosocial model that we often learn in psychiatry is lacking. It ignores a part of [human experience] that is very significant in most people's lives in a way they recognize.*[8]

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[7] Mircea Eliade, *The Sacred and the Profane: The Nature of Religion* (New York, NY: Harcourt Brace, 1959), 14.

[8] Mark Blake [pseudo.], interview by author, audio recording, 25 May 2010.

The persisting hope to strictly enforce a division between hospital-based medical care and religion or spirituality helps explain a failure by either clinicians or academics to positively mark hospital birth as a life-cycle event. Despite its widespread acceptance in the home-birth midwifery community, the idea that religion and spirituality are vital parts of American maternity care is unusual in hospital settings.[9]

THE TRANSITION FROM RELIGIOUS TO MEDICAL AUTHORITY OVER THE BODY

Michel Foucault argues in *The Birth of the Clinic* that modern medicine traces its birth back to the Enlightenment.[10] More specifically, medicine's origins begin in the Enlightenment transition from an emphasis on faith-based Religious meaning, to a scientific and rational basis for meaning and the perusal of ultimate, decontextualized truths through logic and science. A great deal of philosophical attention has been paid to this shift in the evolution of modern thinking. Max Weber describes the secularization of society within a larger process of "the disenchantment of the world."[11] Alasdair MacIntyre has described, "the Enlightenment project of justifying morality,"[12] and Charles Taylor suggests evolving "modern social imaginaries."[13] Two particularly helpful frameworks for contextualizing medicine in this transitional period can be found in the writings of Stephen Toulmin and Michel Foucault.

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[9] Wendy Simonds and Barbara Katz Rothman, *Laboring on: Birth in Transition in the United States* (New York, NY: Routledge, 2007).
[10] Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. A.M. Sheridan (London: Routledge, 2003).
[11] Max Weber, "Science as a Vocation," *Daedalus* 87, no. 1 (Winter 1958): 111-134.
[12] Alasdair MacIntyre, *After Virtue: A Study in Moral Theory*, 2nd ed. (Notre Dame, IN: University of Notre Dame Press, 1984), 49. MacIntyre's virtue ethics are particularly applicable to medicine conceived of as a practice with internal goods
[13] Charles Taylor, *Modern Social Imaginaries*, 3rd ed. (Durham, NC: Duke University Press, 2005).

In his book, *Cosmopolis,* Toulmmin describes the intellectual climate of the seventeenth-century as a "counter-Renaissance."[14] As Toulmin describes it, a shift in consciousness took place during this time from an emphasis on the timely, local and particular that dominated the Renaissance to a focus on logic as the pathway to the discovery of timeless, universal, and decontextualizable truths. The counter-Renaissance—Enlightenment—tradition that Toulmin describes was dedicated to rationality as the best tool for conducting a systematic search for objective truth.

Perhaps more than any other contemporary profession (with the exception of science), medicine purports to be a direct descendant of this counter-Renaissance or Enlightenment thinking. Foucault writes, "Modern medicine has fixed its own date of birth as beginning in the last years of the eighteenth century."[15] Foucault emphasizes medicine's focus on empirical evidence. He situates the birth of modern medicine right around the time of the French revolution with the creation of nation-states, and he describes medicine's function as symbiotic with the decline of the authoritarian church. Heralding the birth of modern medicine, each of these developments epitomizes Enlightenment thinking.

To some extent we can explain medicine's relationship to counter-Renaissance ideals in pragmatic terms. Indeed, many of medicine's great accomplishments have their roots in the systematic search for objective truth that characterized Enlightenment thinking. Medicine greatly benefited from a systematic and empirical examination of human physiology and clinical pathology. And by focusing on disease patterns in a population of patients, physicians were able to achieve unprecedented uniformity in

[14] Stephen Toulmin, *Cosmopolis: The Hidden Agenda of Modernity*, University of Chicago Press ed. (Chicago, IL: University of Chicago Press, 1992), 45.
[15] Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*.

understanding of pathology and physiology. As a consequence, they could effectively diagnose and treat many diseases. But in addition to its pragmatic benefits, medicine also served an important social function in a society that was becoming increasingly focused on logic and reproducibility: science was a particularly appealing tool for an intellectual climate that fostered a search for universalizable truths, and medicine was the ideal conduit for the application of these truths to the human body.

As Davis-Floyd points out, medicine continued to function ritually and symbolically, though not realizing so. Goodman et. al. describe the new faith in rationality and science that paralleled the secularization of Europe in their discussion of the history of human subjects research:

> The progressive secularization of European society from the mid-nineteenth century on was matched by a rising faith in the power of rational science, leading to the emergence of a condition of *logodicy* in which the authority of the church was transferred to science. [16]

After the "counter-Renaissance," the means for interacting with an ultimate reality transitioned from an a-rational focus on faith in God to a faith in rationality. This new faith had its own set of unanswerable questions. Like the religious problem of theodicy, which asked how a benevolent and omnipotent God could allow the suffering of the innocents, the new faith in rationality assumed an ideal of mankind's perfectibility that was irreconcilable with the human realities of finitude and death.[17]

The new ideal of a decontextualized rational truth, discoverable through logical rigor and empirical observation, needed a new establishment through which all people could have access to the new ultimate reality. Just as a hierarchical structured

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[16] Jordan Goodman, Anthony Mc Elligot, and Laura Marks, eds., *Useful Bodies: Humans in the Service of Medical Science in the Twentieth Century* (Baltimore, MD: Johns Hopkins University Press, 2003), 5.
[17] Thomas Hansen, *States of Imagination : Ethnographic Explorations of The Postcolonial State* (Durham, NC: Duke University Press, 2001), 57.

authoritarian church mediated access to God, medicine provided a conduit by which the universalizable truths of science could be applied to the human being and thereby became a new established religion with no less symbolic meaning. As Harold Vanderpool summarizes, "In short, medicine and public health are advancing a way of life to the exclusion of alternatives and in ways that rival or exceed the past power of established religions in the west and the continuing power of Islam across the globe."[18]

Foucault describes one aspect of this assumption of power, the replacement of the traditional clergy with a "therapeutic clergy," [19] in his discussion of the first of two great myths that attended the time period surrounding the French Revolution:

> The years preceding and immediately following the [French] Revolution saw the birth of two great myths with opposing themes and polarities: the myth of a nationalized medical profession, organized like the clergy, and invested, at the level of man's bodily health, with powers similar to those exercised by the clergy over men's souls. [20]

As faith in scientific rationality replaced religious faith as the primary epistemology for Western societies, medicine assumed on many of the functions traditionally performed by the church. In addition to accomplishing many practical goods, it became the religion of the oncoming secular age and doctors became the new priesthood described by Branson.

Both birth and death now take place primarily in hospitals. Both were formerly the domain of religion through the practice of infant baptism and the *ars moriendi*. Illness as well was formerly the domain of religion. Christians established the first hospitals as places to minister for the sick and dying because care for the sick was declared to be a religious duty.

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[18] Harold Y. Vanderpool, "The Religious Features of Scientific Medicine," *Kennedy Institute of Ethics Journal* 18, no. 3 (2008): 221.
[19] Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, 36.
[20] Ibid., 31-32.

Because of the religious importance of medical practice, it is unsurprising that medicine is rife with symbols. Many authors have commented on the vital importance of symbols to religious practice. James Heisig describes symbols as, "the very life's breath of religion,"[21] Huston Smith suggests that, "symbolism is the language of religion generally; it is to religion what numbers are to science" [22] Vanderpool includes symbols as one of his religious features of scientific medicine. He points to the often-overlooked importance of symbols in medicine writing, "Medicine's symbols represent powerful, multi-faceted subtexts that exceed the cognitive and emotional messages of its written and spoken texts."[23] Vanderpool further argues that because they represent a subtext of medical practice, medicine's symbols often go uninterrogated, and even unrecognized though, "they nevertheless display and convey core religious values."[24]

It can be seen as a natural progression that one of the functions of the hospital is religious care for the sick. Indeed, this was *the* focus of the first hospitals, which were Christian institutions designed to minister to the sick and dying. Care for the sick is historically a religious value, one particularly important to the Christian identity in the Western world. One of Jesus' main functions in the gospels is as a healer. For early Christians, caring for the sick was a particularly important part of God's plan and played a role in the overall themes of Christianity, which emphasized the high status of the weak, poor, and powerless in God's eyes. Many early monastic institutions had a mission, inherited by the modern hospital, of care for the sick and indigent. The original focus of the hospital, whose name takes its root from the Latin word for hospitality

[21] James Heisig, "Symbolism," in *The Encyclopedia of Religion*, ed. Mircea Eliade and Charles J Adams (New York: Macmillan, 1987), 198.
[22] Huston Smith, *Islam: A Concise Introduction* (San Francisco: HarperSanFrancisco, 2001), 82.
[23] Vanderpool, "The Religious Features of Scientific Medicine," 217.
[24] Ibid.

towards strangers, was on Christian, religious care for the sick and dying. Because, as Darrel Amundsen and Gary Ferngren write, "The New Testament was clear in teaching that one could not claim to love God without also loving one's fellow human beings." [25] They similarly characterize the valuation of sick and dying strangers as a particularly Christian phenomenon, for the most part foreign to Roman culture.

Hospitals have historically been religious institutions. The shift from hospitals as home for the indigent poor who were dying, to hospitals as places where people expected to be rescued paralleled a shift from Christianity to science as the main ministration available. Therefore it is natural that many of the religious functions of the original hospital were subsumed by scientific functions of nurses and physicians. For example, it was during this period that the white coats of lab science replaced the older black garments traditionally worn by clerical hospital workers. [26]

In obstetrics, ritual and symbolic aspects of medical care continued to pervade clinical practice. As Davis-Floyd points out, contemporary Western childbirth is rife with symbolic content. Religious terminology abounds in descriptions of the uterus, even in contemporary texts. The implication is often that the uterus functioned as a sort of sanctuary for the fetus before the advent of modern obstetrics, but it is now exposed for scientific observation. For example, George J. Annas and Sherman Elias describe how thalidomide shattered the view that the fetus was protected from maternal drug exposure by "the sanctum sanctorum of the uterus." [27] And one recent medical textbook describes

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[25] Darrell W. Amundsen and Gary B. Ferngren, "The Early Christian Tradition," in *Caring and Curing: Health and Medicine in the Western Religious Traditions*, ed. Ronald L. Numbers and Darrel W. Amundsen (Baltimore, MD: The Johns Hopkins University Press, 1997), 51.
[26] Dan W. Blumhagen, "The Doctor's White Coat," *Annals of Internal Medicine* 91, no. 1 (July 1, 1979): 111-116.
[27] G J Annas and S Elias, "Thalidomide and the Titanic: Reconstructing the Technology Tragedies of the Twentieth Century.," *American Journal of Public Health* 89, no. 1 (January 1, 1999): 89.

ultrasounds as allowing the "light of scientific observation [to] fall on the shy and secretive fetus." [28] University of California at San Francisco fetal surgeon, Michael Harrison highlights the profound significance of the physician's new ability to see into the womb in his textbook titled, *The Unborn Patient: The Art and Science of Fetal Therapy*. He writes: "Historically, we approached the fetus with a wonder bordering on mysticism . . . [This was] the awe engendered by a scene that no one had actually witnessed." [29]

Even though the religious or mystical significance of the womb as sanctuary is often associated negatively with a pre-scientific understanding of the fetus, the religious or mysterious elements of new life are not completely eliminated with the advent of new obstetric technologies. The womb formerly constituted an opaque sanctuary, but with the light of scientific medicine, the religious significance of the gestation could be transferred to the physician. Barry Schifrin writes in his text on fetal monitoring that, "the fetus [is] no longer the reclusive, silent, inaccessible creature that leaves its sanctuary for medical care at the very last moment. The fetus has become amenable to our ministrations, interventions, and understanding." [30] Shifrin's use of the word, "ministrations" hints at the religious function of the modern physician that has we have seen elaborated upon by Foucault.

An analysis of the recent development of commercially available 3D ultrasound illustrates the ritual importance of obstetric technology as well. At a shopping mall in Katy, TX there is a store called "Peek A Baby 3D." The proprietors offer three and four-

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[28] Michael Harrison, *The Unborn Patient: The Art and Science of Fetal Therapy*, 3rd ed. (Philadelphia: W.B. Saunders, 2001), 3.
[29] Harrison, *The Unborn Patient: The Art and Science of Fetal Therapy*.
[30] Cydney I. Afriat and Cydney Afriat Menihan, *Electronic Fetal Monitoring* (Rockville, MD: Aspen Publishers, 1989).

dimensional ultrasound to expecting mothers in exchange for payment. This service has been met with a great deal of controversy and resistance by obstetrician gynecologists who are concerned about medical technology being offered outside the confines of a hospital or doctor's office. The resistance to ultrasound being bought and sold outside the hospital is expressed in terms of concern over exposure of the fetus to unnecessary radiation. Yet obstetricians routinely provide late term ultrasounds to patients in their care despite compelling evidence suggesting this procedure does not improve outcomes. [31] Physician resistance to commercially available three-dimensional ultrasounds may be better explained by the metaphor of moneychangers in the temple: physicians are uneasy with a violation of "the sanctum sanctorum of the uterus" for profit alone rather than for the medical care they provide.

Despite the continued importance of ritual and symbolic content in obstetric care, frank discussions of the ritual functions of obstetric practice are rare among clinicians. The next section will explain this resistance by investigating medicine's enduring attachment to its modern identity. Looking at narratives in which the numinous elements of childbirth are overtly acknowledged from the perspective of the modern constitution helps explain the persistent marginalization of spirituality and religion in hospital maternity care.

CHILDBIRTH AND RELIGION, PRE-MODERN AND MODERN NARRATIVES OF BIRTH

This section will examine three groups of narratives in which the associations between childbirth and the numinous are overt. First I will examine, anthropological studies of non-Western birth practices. Second, I will examine historical accounts of

[31] The Cochrane Collaboration, *Cochrane Database of Systematic Reviews* (Chichester, UK: John Wiley and Sons, Ltd, 1996), http://www.cochrane.org/reviews/en/ab001451.html.

midwifery practice from the Early-modern West, and finally I will examine contemporary writings concerning home-birth midwifery. Though these narratives are diverse, they share a common theme: each characterizes birth as something both biological and symbolic, material and spiritual. By contrast, narratives common in allopathic medical practice attempt to reduce birth to its biologic function.

I will explore obstetric narrative genres in more detail in Chapter 3. For now, notice how narrative forms in each of these three non-modern genres might be read by a reader advocating for a secular and modern medical practice. Both clinicians and lay people are often invested in the idea that medicine represents a purely biological, scientific practice. This results in a devaluation of the ritual and symbolic components of medical narratives. In anthropological narratives of indigenous medical systems, a focus on the symbolic, ritual, and non-material aspects of maternity care make the cultures in question seem arational and pre-modern. In Early-modern midwifery narratives, the focus on the religious aspects of birth is read as an inappropriate intrusion of religion into medical practice. And in narratives from home-birth midwifery, the focus on the spiritual or transcendent aspects of birth takes place in a context that sets itself up as decidedly counter-culture, embracing a rhetorical style that would alienate someone steeped in the modern constitution.

In her study of religion, spirituality and home birth in America, religious studies scholar Pamela Klassen suggests succinctly that, "the childbearing body is a begetter of profound meaning."[32] Diverse texts from historical and contemporary sources affirm Klassen's assertion. Childbirth historically has been invested with a great deal of

[32] Pamela Klassen, *Blessed Events: Religion and Home Birth in America* (Princeton, NJ: Princeton University Press, 2001), xii.

symbolic meaning, and continues to function symbolically in contemporary culture despite a widespread marginalization of spirituality and religion in modern obstetric practice.

Childbirth did not come into its own as a legitimate field for anthropological inquiry until well into the 1970's with Brigitte Jordan's groundbreaking work, *Birth in Four Cultures*.[33] This is not surprising since childbirth tends to be a woman only space, while anthropology, until quite recently, was a male dominated field. This meant that access to ethnographic opportunities in non-Western birth settings was difficult for anthropologists writing before the mid twentieth century and accounts for the dearth of anthropological writings on non-Western birth. In the West, early and mid 20th century anthropologists tended to see male-attended Western birth practices, which they might have had better access to, as purely medical or biological events that were beyond the scope of ritual studies.[34]

The anthropology of childbirth came into its own in the midst of various feminist and women's health movements of the 1960's and 70's. Steeped in this culture, many early texts are concerned with matters of women's bodies in terms of a broadly construed political power (where, as the authors of the famous women's health text *Our Bodies, Ourselves* contest, the personal is seen as political). Though ritual in Western obstetrics was explored in great detail, perhaps most famously in Davis-Floyd's *Birth as an American Rite of Passage,* the absence of any woman-centered spirituality or religion in contemporary American childbirth was often taken for granted.

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[33] Robbie Davis-Floyd and Carolyn Sargent, eds., *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives* (Berkeley: University of California Press, 1997).
[34] Ibid.

The majority of contemporary anthropology of birth, particularly of American maternity care, generally does not focus overtly on issues of religion or spirituality in childbirth. In contrast the existing writings on anthropology of birth before the 1970's highlight religious and spiritual practices. Among the earlier writings from medical anthropology that do hone in on birth practices, the focus is often exclusively on the host of religious, magical, or spiritual meanings that attend childbirth, pregnancy, and miscarriage across a diverse range of cultures. And though these texts have been more recently maligned as, "long lists of seemingly irrational food taboos and folk beliefs,"[35] they do suggest something important: that early Western anthropologists perceived an association between childbirth and the supernatural in non-Western cultures.

James Frazer's classic 1900 text, *The Golden Bough,* for example, describes a myriad of magical and religious beliefs among so-called primitive religions that surround childbirth, pregnancy, and miscarriage. Interestingly, many of Frazer's descriptions fall into two oppositional, but related categories: practices that suggest important supernatural powers surrounding women's reproductive capacities, and practices that stigmatize women's embodiment. Frazer describes myths that elaborate the mystical powers possessed by pregnant or menstruating women, for example his vivid description of a belief from Greenland wherein, "a woman in child-bed and for some time after delivery is supposed to possess the power of laying a storm. She has only to go out of doors, fill her mouth with air, and come back into the house and blow it out again."[36]

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[35] Robbie Davis-Floyd and Carolyn Sargent, eds., *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives* (Berkeley and Los Angeles, CA: University of California Press, 1997), 1.
[36] James Frazer, *The Golden Bough: A Study in Magic and Religion* (New York, NY: Simon and Schuster, 1900), 93.

Alongside rituals and symbols that suggest mystical or spiritual power inherent in women's embodiment, Frazer also describes many taboos that serve to stigmatize women's reproductive capacities, or mysterious embodiment, for example, a practice among Alaskan natives where women after childbirth cannot be touched and must have their food handed to them on sticks, the stigma being even more extreme in the case of a stillbirth.

In some instances the connection between spiritual and medical practices in these narratives is so fundamental that it becomes difficult to differentiate the two. For example, Claude Levi-Strauss' suggests magico-religious ritual as medical intervention in his now-famous description of a shamanistic birth incantation he witnessed during his fieldwork with the Cuna Indians in South America. A male shaman, at the request of a midwife, will recite an incantation recounting a spiritual journey into the womb, which removes the obstacles to a difficult labor. Levi-Strauss suggested that this practice was a legitimate tool for treating dystocia that functioned by way of a connection between the psychological and physiological states made by the laboring woman.

He writes:

> The intervention of the shaman . . . occurs in case of failure, at the request of the midwife. The song [describes] fumigations of burnt cocoa-nibs, invocations, and the making of sacred figures, or *nuchu*. These images, carved from prescribed kinds of wood . . . represent tutelary spirits whom the shaman makes his assistants and whom he leads to the abode of *Muu*, the power responsible for the formation of the fetus.[37]

Levi-Strauss' writing seeks to elevate the shaman's incantation to the status of legitimate medical intervention, however the rhetorical style it embraces is alienating to a reader steeped in the discourse of medicine as modern. The anthropologist and obstetrician

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[37] Claude Lévi-Strauss, *Structural Anthropology* (Basic Books, 1963), 187.

Lewis Wall, for example, maligns this text as an example of the myth of the noble savage, in which primitive women are expected to labor without complication.[38]

Discussion of the immaterial aspects of childbirth are not limited to narratives about non-Western cultures. The history of Western midwifery is rife with examples of the central place of religion in childbirth. Historian Hillary Marland, for example, writes about the importance of religion in early modern midwifery licensing. Conformity of midwives to specific religious standards was paramount since the midwife was responsible for presenting an infant for baptism, leading a churching procession, and even baptism itself in the case of an emergency.[39]

In addition to non-Western cultures and early-Modern Western cultures, a pervasive association of spirituality with childbirth exists in contemporary home-birth midwifery literature. This phenomenon is perhaps most evident in Ina May Gaskin's classic text, *Spiritual Midwifery*. Gaskin is a midwife at the famous commune, the Farm, in rural Tennessee. Gaskin's midwifery manual, the bulk of which consists of birth stories from women who gave birth on Gaskin's commune in rural Tennessee, positions spirituality as the central focus of childbirth. The first edition was published by a press on the commune itself, and most of the birth stories included describe birth as a spiritual experience, even describing it as a sacrament. The book is decidedly dated, including 1960's style pen illustrations, poetry, and photos of bearded and long-haired families living on the Farm. The prose is similarly entrenched in the spirit of the anti-establishment movements of the 1960's, commonly using words like "psychedelic" to describe childbirth experiences and describing contractions as "rushes of energy."

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[38] Lewis Wall, "The Noble Savage in Labor; or, Claude Levi-Strauss Has a Baby," *Perspectives in Biology and Medicine* 40, no. 1 (1996): 33-44.
[39] Hilary Marland, *The Art of Midwifery* (London, UK: Routledge, 1994).

Despite its dated appearance, Gaskin's text is currently required reading for many direct entry midwifery programs and is listed on the North American Registry of Midwives entrance exam, the main licensing board for direct entry midwives in the United States and Canada. Readers from the perspective of medicine as a modern practice might find the text alienating in its active rejection of mainstream modern institutions.

CONTEMPORARY OBSTETRICS: MODERN NARRATIVES

If religion, magic, and spirituality hold a central place in childbirth both in historical and contemporary practices, and in both Western and non-Western cultures, what accounts for the dearth of emphasis on spirituality in American hospital birth? I have given examples of the importance of spirituality in childbirth in anthropological descriptions of non-Western cultures, in the history of childbirth in the West, and in non-mainstream contemporary American culture. But the examples I have pointed to may not convince a mainstream reader of the importance of spirituality in birth to mainstream contemporary childbirth. Indeed, each of the three broad categories may seem particularly unconvincing for someone steeped in the discourse of modern medicine. These examples may even entrench notions that religion and spirituality have no place in modern maternity care.

For a reader convinced that a modern obstetrics, purified of religious or ritual, functions is the best system of maternity care, all of these descriptions work to set up a savage, *other* against which modern medicine can define itself. Descriptions of childbirth practices from midcentury anthropology evoke images of a strange otherworldly magic more than any kind of religion or spirituality a contemporary American can relate to. The seemingly inordinate fascination of sixteenth-century Englishmen with the religious purity of midwives appears an inappropriate intrusion of religion into medical practice.

Likewise, descriptions of spiritual births on a commune may seem laughably dated, or dangerously naïve, making sense only in a time when idealism went unchecked, or even evoking what philosopher Robert Solomon calls the, "'new consciousness' pap that passes itself off as non-sectarian spirituality."[40] None of these narratives are appealing to a mainstream medical reader. While medicine posits itself firmly as a modern practice, the commonality among the examples I have pointed to is that each describes childbirth practices that appear decidedly not modern.

The natural tendency of a Western reader is to read childbirth narratives (and medical narratives in general) in the context of what Bruno Latour has called, "the modern constitution." Though the current academic climate can be well-described as dominated by post-modern ideals, Western medicine stands out in many ways as a decidedly Enlightenment driven practice. The way most Americans think of medical practice, and the way medicine conceives of itself is in many ways peculiarly modern. Medicine holds fast to many Enlightenment hopes long abandoned by mainstream contemporary academia. Despite the ascendancy of postmodernism in the academy, medicine still embodies what historian Paul Starr has called, "the dream of reason," the dream that the rational application of scientific principles will eventually alleviate or even end human suffering and death. Medical practice hopes to establish timeless, decontextualizable truths about the body, and it inherits from Enlightenment culture in its enduring emphasis on the visible.

It is unsurprising that medicine holds tight to these ideals. They seem the very aspects of medicine's identity, beginning in the early modern practice of dissection and

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[40] Robert Solomon, *Spirituality for the Skeptic: The Thoughtful Love of Life* (Oxford, UK: Oxford University Press, 2002), xii.

perhaps culminating with the mid-century development of antibiotics, that assisted in the development of a host of useful therapeutics and paralleled an unprecedented improvement in vital statistics, including a culture-altering dramatic decline in both infant and maternal mortality (though the attribution of these improvements to allopathic interventions has been called into question). But they also led to a simultaneous decline in emphasis on that which could not be made visible, or empirically validated. Religion, emotion, and spirituality, long considered vital aspects of childbirth, became symbolic of a pre-modern culture that was ruled by superstition. Modern medicine set itself apart from these modes of understanding, as it simultaneously promised deliverance from the eminent risk of death (and later pain as well) that historically attended childbirth.

Recall that Foucault posits the Enlightenment as the time period where, "modern medicine . . . fixed its own date of birth."[41] For Foucault, medicine embraces a positivistic understanding of the human body that is (purportedly) based on empiricism. Medicine, he writes, "identifies the origin of its positivity with a return—over and above all theory—to the modest but effecting level of the perceived."[42] Again, I want to emphasize the fundamental practical gains made possible by this focus on the visible. Even Latour's scathing critique of modern medicine, *The Pasteurization of France,* admits a striking, almost magical quality that attended the clinical application of developments in medical practice. For all its faults, the rise of the clinical gaze also allowed practical developments so impressive that they seemed like magic to many of their contemporary witnesses and still seems so to many contemporary Westerners.

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[41] Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (New York: Vintage Books, 1994), xii.
[42] Ibid.

The hope for a "modern" approach to medicine is particularly appealing in birth, which obstetrician Anne Drapkin Lyerly has called, "the utterly out-of- control activity of parturition."[43] Long associated with a palpable fear of death and a great deal of pain, modern obstetrics offered a paradigm in which the capricious female body could be made to function in a relatively standardized fashion, progressing along a predictable curve, and augmented or slowed with the help of pharmaceuticals. It offered truly miraculous therapeutics in the form of antibiotics and oxytocics that dramatically influenced the palpable risk of maternal death from birth, and it made thinkable, understandable, the unpredictable, out of control process of childbirth.

But in addition to the laudable gains that the this emphasis on empiricism and the application of scientific principles to the human body made in terms of successful therapeutics, the extreme emphasis on that which can be seen also had far-reaching negative consequences. Among these were a resulting devaluation of non-visible and non-rational aspects of healing, in particular a marginalization of spirituality in medical practice in general and in obstetrics in particular.

Toulmin writes:

> The Cartesian program for philosophy swept aside the 'reasonable" uncertainties and hesitations of 16th century skeptics, in favor of new, mathematical kinds of 'rational' certainty and proof. In this it may (as Dewey and Rorty argue) lead philosophy to a dead end. But for the time being, that change of attitude—the devaluation of the oral, the particular, the local, the timely, and the concrete—appeared a small price to pay for a formally 'rational' theory grounded on abstract, universal, timeless concepts."[44]

Though the hopes of the "counter-Renaissance" Toulmin describes have been largely debunked in most academic circles (by scholars like Dewey and Rorty), they persist

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[43] Anne Drapkin Lyerly, "Shame, Gender, Birth," *Hypatia* 21, no. 1 (2006): 111.
[44] Stephen Toulmin, *Cosmopolis: The Hidden Agenda of Modernity* (New York, NY: Free Press, 1990), 75.

mightily in the context of medical practice. While philosophers in the past thirty years have tried to undermine this hope, "for a formally 'rational' theory grounded on abstract, universal, timeless concepts," medicine remains in many ways committed to the search for timeless, abstract, and universal truths. Perhaps this is because the benefits of this approach have been so dramatic in medicine, or because when issues of the vulnerable body are at stake, humans tend to turn to the most culturally sanctioned modes of healing.

Whatever the reason, contextualizing medicine as a stalwartly modern, Enlightenment driven practice helps explain why, rather than elevating the status of the supernatural in childbirth, the descriptions I have laid out of childbirth practices that emphasize spirituality may have had the opposite effect on a reader attached to medicine's modern identity. The narratives of indigenous childbirth practices from medical anthropology in particular use descriptions that set up an *Other* against which the modern constitution is formed. Narrated by Western social scientists steeped in the discourse of modernity, descriptions of non-Western birth practices often embrace rhetoric that diminishes their validity, relegating them to the status of either magic or superstition rather than either legitimate medicine or legitimate religion. They suggest that an emphasis on symbolic thinking, or the use of ritual in childbirth is something fascinating, and primitive, even savage.

Early twentieth century writings in the history of medicine served a similar purpose by defining the field of medicine as an Enlightenment-driven narrative of linear forward progress. This is true to such an extent that medical history was for decades disdained by professional historians as a field only suited for physicians who wished to write uncritical narratives of advances in their own field. Medical history before the 1970's was dominated by progress narratives and biographies that tended to be written

with such a tone of uncritical praise that many were maligned by later historians as "hagiographies," after the Catholic tradition of stories about Saints.

Midcentury histories of obstetrics and gynecology in particular are often chronicles of successive advances in the field, citing progressively declining maternal and infant mortality, and chronicling an uncritical narrative of increasing technological intervention, medicalization, and hospitalization as progress. Medical history has changed radically in the past thirty years to become increasingly critical of the Enlightenment-steeped narrative of progress but the positivist genre of the history of medicine is still very influential for lay people, physicians, and academics. For this reason, when one reads medical literature from the Early Modern period, it is often with an eye for discerning kernels of what seems medically sound to the contemporary reader from a sea of irrational beliefs to be later discarded. Indeed, this idea of the Renaissance as a chronicle of early developments into rational, modern thinking is implied by the term itself. "Early modern," suggests the period as modernity in infancy, its medicine slowly beginning to embrace modern ideals and shed the irrational past from which the modern practice of medicine triumphantly emerged.

Similarly distasteful to the scrutinous eye of the modernist perspective are contemporary descriptions from home-birth midwifery communities. These midwives and their kith deliberately set themselves up in contrast to modern ideals. Davis-Floyd describes that the midwife must move, "beyond uncritical acceptance of modernization as good, noting the enormous environmental, social, and cultural damage modernization entails." [45] That *Spiritual Midwifery* is set on a commune matters. The folks who went to the Farm often did so because they embraced a back-to-nature philosophy, desired to

[45] Robbie Davis-Floyd, "Daughter of Time: The Postmodern Midwife," *Unpublished manuscript* (2004): 2.

eschew many modern conveniences, and believed that the way of life made possible by Enlightenment narratives was ultimately bankrupt.

The absence of a discourse of the numinous in birth is related to a firmly entrenched modern identity. Eliade suggests removal from religion as one of the fundamental aspects of modernity, writing, "'modern man's originality, his newness in comparison with traditional societies, lies precisely in his determination to regard himself as a purely historical being, in his wish to live in a basically desacralized cosmos."[46] As a practice that identifies itself as decidedly modern, American maternity care similarly sets itself up in contrast to childbirth narratives that view the spiritual, ritual, and symbolic elements of childbirth as something vital. The result is an unfortunate lack of attention to an important element of childbirth. Modern obstetrics distinguishes itself from non-modern culture, and asserts its own modernity by attempts to divorce itself from the ritual practices that historically played such vital roles in childbirth.

Of course, contemporary Western science and medicine is not removed from symbolic and magical thinking. But in contemporary discussions of birth, the dichotomy between savage and modern is reconstituted in a novel way. In the same way that traditional Western anthropology legitimated colonial practices by setting up a dichotomy between the savage and the civilized, early medical anthropology invokes as its *other* a magical, ritualistic form of medical practice, against which the modern practice of medicine can define itself. Latour explains the difference between our scientifically mediated morality of the heavens, and that of pre-modern culture, thusly:

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[46] Mircea Eliade, *Rites and Symbols of Initiation: The Mysteries of Birth and Rebirth*, trans. Willard Trask (New York, NY: Harper Torchbooks, 1958), ix.

> But we are not savages; no anthropologist studies us that way, and it is impossible to do with our own culture . . . what can be done elsewhere, with others. Why? Because we are modern"[47]

For Latour, our attachment to a modern identity makes critical appraisal of the ritual functions of Western science and medicine difficult, if not impossible. He writes, "For traditional anthropologists, there is not . . . an anthropology of the modern world."[48]

Latour is mistaken. An anthropology of the modern world, or more specifically an anthropology of modern obstetrics, is precisely what characterizes the contemporary anthropology of birth. Steeped in a discourse that questioned the legitimacy of the powerful institution of medicine and its control over women's bodies, the contemporary anthropology of birth relies on the distinction between enlightened modern and savage other that Latour points out. Latour's suggestion, "we are not savages; no anthropologist studies us that way," helps explain the enduring influence that Davis-Floyd's *Birth as an American Rite of Passage,* has had, not just on the anthropology of birth, but on the contemporary midwifery movement at large. This classic in the field takes the dichotomy between the pre-modern ritually-influenced savage and the rational, scientific modern and turns it on its head. Recall that her book evaluates specific obstetric practices common in the 1970's and 80's, for example, enemas, lithotomy position, and episiotomy, as well as practices like continuous electronic fetal monitoring which persist today. Davis-Floyd considers the obstetric explanation, what she terms the "institutional rationale" for performing these procedures, she then looks at evidence from within the field of medicine that often debunks the proffered institutional explanation, and then explains the underlying ritual purpose of each practice.

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[47] Bruno Latour, *We Have Never Been Modern* (New York, NY: Harvester Wheatsheaf, 1993), 7.
[48] Ibid.

Davis-Floyd's *Birth as An American Rite of Passage* might be considered a surprising twist on a narrative genre from early medical anthropology, in which an association of a specific culture of maternity care with ritual practices suggested an unenlightened, pre-modern, even savage approach to birth. In doing so, she sets up characters we recognize and identify with. But in her narrative, it is the obstetrician who takes the role of the pre-modern *other*, since his practices only purport to have rational scientific explanations, but are, in fact, nothing more than savage rituals.

This is a beautiful, and rhetorically profound move, and one that has had lasting consequences for the contemporary midwifery movement that is increasingly taking up the banner of evidence based medicine to promote midwifery model care. But it is also a limited critique in that that it still sets up a ritually influenced, pre-modern *other* (this time scientific obstetrics) that a reconstituted group of moderns (midwives) define themselves against. Bruno Latour says of the modern constitution that it, "provided the moderns with the daring to mobilize things and people on a scale that they would otherwise have disallowed."[49] This insight is applicable to the modern midwifery movement, which is increasingly making strides in contemporary America with arguments about home birth that focus on evidence and hone in particularly on the idea that home birth decreases both infant and maternal morbidity and mortality. This is clearly an important development, but the trend towards emphasizing the objective and scientific benefits of midwifery model care must not come at the exclusion of a serious discussion of the symbolic and ritual importance of birth with the potential affirm women's spirituality. The recognition of obstetrics as a ritually influenced, symbolic practice is only a first-step, since the problem, of course, is not merely the existence of

[49] Ibid., 41.

rituals masquerading as science, but the kind of values and beliefs those rituals secretly enforced, and, as Foucault and Starr point out, the power dynamics they created.

This is an essential distinction if we are to take seriously the role of religion or spirituality in childbirth. Bioethicist Courtney Campbell argues that religious traditions are, "so symbolically laden . . . that efforts at communication without symbols may be considered, both by members of the community and by outsiders, as nonsense." Religion generally concerns itself with symbolic meaning, while medicine or science hopes to concern itself mainly with logical, empirically oriented truths. In order to take seriously the relationship between childbirth and religion or spirituality, we will also have to take seriously the symbolic or ritual content of Western birth—not just critically, but also constructively. This means not only exposing ritual and symbolic practices for what they are, or even illuminating the negative consequences of the set of symbols and rituals that American obstetrics adopts, but also recognizing that human interaction in general, and medicine in particular *must* play symbolically and ritually significant functions in the lives of women if birth is to be the profoundly positive, transformative experience the contemporary midwifery movement says it can be.

Where does this leave those who argue that medicine should be secularized or purified of its symbolic content? Healing and birthing systems are inevitably rife with symbolic and ritual content. The contemporary anthropology of birth offers a good starting point by deconstructing a view of medicine as a purely rational or scientific endeavor. The modern hope to purify medical practice of all symbolic or religious meaning, to eschew premodern ritual practices as magic or superstition was naïve: at their root, all human endeavors, mediated by language, are symbolic in nature. As Latour puts

it, "we have never been modern," [50] in that our scientific explorations have never succeeded in purifying themselves of symbolic content, and what moderns hoped was naked factual information about the natural world, was in reality an indivisible chimera of "nature-culture." [51]

Even if we accept that medicine cannot be purified of its symbolic content the question remains of whether or not attempts to move towards secularization might be harmful or helpful. Is Branson right in his earnest call for a move towards secularization? Must the priestly function of medicine mean that physicians only wield its power to effect oppression and alienation? Does the ritualistic importance of medical interventions necessitate their continued use even when they jeopardize both the birth experience and the health of patients? I believe that the answer to all of these questions is an emphatic no and that any attempts to entirely secularize medicine will leave it devoid of its most vital and precious functions. What is needed instead is a serious appraisal of the ritual, symbolic, and religious functions of medicine. Only when we acknowledge these aspects of medical care overtly can we think critically about which symbols and rituals we want to employ, and what messages those practices will convey to patients.

Insofar as they have been successful, past attempts to create entirely secularized medicine have ended in debacle. They have enabled us to surrender the sacred task of caring for the sick and needy to big business interests intent on profiting off human suffering. Secularization also undermines caring for the dying with human compassion, rather than with additional technological intervention. It has reduced the sacred covenant that binds physicians and patients to a contract to be negotiated in the marketplace. And it

[50] Latour, *We Have Never Been Modern*.
[51] Ibid., 7.

replaces principles like mercy, kindness, and compassion with marketplace ideals like efficiency, autonomy, and consumer-choice.

The ideal midwife that Davis-Floyd describes must not fall into the trap of aspiring to be modern by dismissing obstetric birth practices as mere ritual, if she hopes to embrace the spirituality that is vitally important to childbirth. She, and her obstetrician counterparts, must instead carefully consider which rituals, either technological, religiously derived, or personally developed, they will adopt and why. As Klassen suggests of the women in her home birth study, "they are not content to consider birth and maternity either irredeemably sullied by long-held patriarchal projections or hopelessly disenchanted by medical procedure."[52] Klassen argues that childbirth has "the enduring power . . . to foster religious reflection and initiate religious practice."[53] I would like to argue that the same is true for hospital birth. But if we are to take spirituality in hospital birth seriously, we must also take seriously the idea that hospital-based Western birth rituals can also have sacral power, and mystical, religious, or narrative benefit.

[52] Klassen, *Blessed Events: Religion and Home Birth in America*, xiii.
[53] Ibid.

Chapter 2:

The Marginalization of the Feminine in Religion

> *Women are a constant source of malignant influence . . . They bring misery and witchcraft. They possess the evil eye. It is for this reason that they play a more important role in magic than in religion.*[1]
>
> -Mauss and Hubert, *A General Theory of Magic*, 1904

Spirituality and religion are doubly marginalized in American hospital birth. First, as detailed in Chapter 1, birth is considered a medical event in America culture. As a consequence, it is characterized by a focus on the reproducible and empirical that attends modern medical practice. The modern desire to biologize and desacralize the body resulted in a strict dichotomy between healing and birthing practices, which were supposed to be devoid of ritual and symbolic meaning, and religion, which was the appropriate place for ritual observance and contemplation of the sacred. The non-religious modern hopes to exist in what Eliade has called, "a wholly desacralized cosmos."[2] Meanwhile, for those who wish to preserve some element of sacred experience, religion, wholly separate from medicalized healing and birthing practices, is the major acceptable outlet.

The marginalization of the spiritual in medical care is problematic for medical practice in general and, more specifically, in the hospital experience, where bodily vulnerability can manifest itself in an uncomfortable encounter with the *mysterium*

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[1] Marcel Mauss, *A General Theory of Magic,* 1904 (New York, NY: Routledge, 2001), 148.
[2] Mircea Eliade, *The Sacred and the Profane: The Nature of Religion* (New York, NY: Harcourt Brace, 1959), 13.

tremendum. But for birth, the problem is even further magnified, since the major religious traditions generally available to Westerners are various forms of patriarchal monotheism that historically marginalized and stigmatized the embodied experience of women.

Furthermore, from an academic perspective, a traditional dichotomy between religion and magic contributed to a condemnation of ritual practices associated with women's embodied experience. This dichotomy elevated religion, categorizing many of the rituals surrounding female embodiment in the negatively stigmatized category of magic. The difficulty of finding women's space in Western religious and spiritual practice creates a double bind for women and providers who wish to sacralize their experience of hospital birth. Birth is stripped of its sacred value by biologization and medicalization, while the appropriate conduit for sacred experience, Western religion, devalues women's embodied experience.

This chapter will focus on the marginalization of women's embodied experience in religion for a culture in which numinous experience is often interpreted via Western monotheism. First, I will define the terms *religion* and *spirituality*, starting with the definitions provided by academics, but relying heavily on the distinctions made by the women and providers I interviewed. As terms, both *religion* and *spirituality* are problematic when describing embodied experience. Secondly, I will examine the dichotomy between religion and magic in social science and religious studies that tends to marginalize women's embodied experience as a legitimate form of sacral expression. Finally, I will move to an investigation of the ways in which women's embodied experience is marginalized and stigmatized in Western monotheism.

Despite the difficulties that both American medicine and religion impose on sacralizing birth, both women and providers continue to experience and articulate their hospital births as sacred events. The remainder of this dissertation will examine this

phenomenon in detail. This chapter will end by gesturing to ways in which providers and patients use acts of moral bricolage to sacralize their experience of hospital birth in contexts that are both medicalized and religiously patriarchal.

DEFINING RELIGION AND SPIRITUALITY

> *Religion requires a god who's paying attention to you and has rules he wants you to follow. Spirituality doesn't.*[3]
>
> -Eva Jacobs

Religion is a difficult term to define. Generally assumed to be a system of faith or worship involving rituals, observances, gods or goddesses (whether singular or plural), and belief in the supernatural, the definition of religion is a highly debated topic.[4] Sociologists of religion have pointed out that most definitions of religion either require qualities that do not exist in all religions (for example, belief in a God or gods leaves out Taoism and Buddhism) or allow things that are not generally considered religions (nationalism, for example) to be classified as such. Andrew McKinnon proposes a non-essentialist definition of religion based on Ludwig Wittgenstein's model of family resemblances, suggesting that if something meets a great number of the qualities generally associated with religion, then it can be classified as a religion.[5] The debate over the definition of religion is particularly germane to medical humanists who note that

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[3] Eva Jacobs [pseudo.], interview by author, audio recording, 11 June 2010.

[4] *The Oxford English Dictionary*, 3d ed., August 2010; online version November 2010, s.v. "religion"; Daniel S. Goldberg, "Religion, the Culture of Biomedicine, and the Tremendum: Towards a Non-Essentialist Analysis of Interconnection," *Journal of Religion and Health* 46, no. 1 (9, 2006): 99-108.

[5] Andrew McKinnon, "Sociological Definitions, Language Games, and the "Essence" of Religion," *Method and Theory in the Study of Religion* 14, no. 1 (2002): 61-83.

contemporary biomedical practice (including obstetrics) has a great number of the features of religion that McKinnon articulates.[6]

Two religious studies scholars, Susan Star Sered and Pamela Klassen, have pointed out that women tend not to use the word *religion* to define their birth experiences.[7] Sered points to an apparent contradiction: her subjects, mostly practicing Jews, did not describe their birth as a religious experience, but often agreed with the sentiment that a miracle had happened. Similarly, Klassen's subjects often reported that birth for them was a spiritual experience, but not a religious one. Part of the rationale behind this distinction is that, particularly in cultures where Abrahamic monotheism prevails, specific religious rituals surrounding women's rites of passage are often lacking. Furthermore, women sometimes feel inadequately represented by the patriarchal aspects of monotheism. Many of the women and providers I interviewed pointed to the inadequacies of religious systems for describing women's spirituality. Marion Graves Wilder, a young Lutheran mother, elaborates:

> *Growing up in [household that had] a very dogmatic, male dominated, very literal interpretation of biblical scripture was hard. And not feeling like I had a place in society: women did nothing in the church but play the organ or the piano. And I had a lot of questions, even as a very young child: "What's peace on earth, good will to men?" I mean that really was disturbing for me because I didn't understand where I fit. That was at a very young age: six or seven.*[8]

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[6] Goldberg, "Religion, the Culture of Biomedicine, and the Tremendum"; H. Y. Vanderpool, "The Religious Features of Scientific Medicine," *Kennedy Institute of Ethics Journal* 18, no. 3 (2008); Margaret P. Wardlaw, "American Medicine as Religious Practice: Care of the Sick as a Sacred Obligation and the Unholy Descent into Secularization," *Journal of Religion and Health* 50, no. 1 (1, 2010): 62-74.

[7] Susan Starr Sered, "Childbirth as a Religious Experience? Voices from an Israeli Hospital," *Journal of Feminist Studies in Religion* 7, no. 2 (Fall 1991): 7-18; Pamela Klassen, *Blessed Events: Religion and Home Birth in America* (Princeton, NJ: Princeton University Press, 2001).

[8] Marion Graves Wilder [pseudo.], interview by author, audio recording, 10 May 2010.

Providers also emphasized the difficulty of practicing obstetrics within the context of religion. "There are many religions that punish women, don't you think?" obstetrician Beverly Mason asked me.[9] She also pointed to the anti-choice views of Catholicism in particular, pointing to a tension between practicing obstetrics in a feminist way and adhering to a religious ideology.

Klassen points to a tendency among her subjects to privilege the term *spirituality*, casting it a more positive light than the word *religion*. Her interviewees tended to view spirituality as more authentic to the birth experience than religion, and condemned religion as overly rigid and disconnected from women's experience. This, she points out, is the opposite of the attitude embraced by most religious studies scholars, in which spirituality is considered a softer, less authoritative form of approaching the sacred. My research subjects, as a general rule, tended to validate this idea. Wilder, for example, confirmed this attitude, saying:

> *I see religion as the practice, the tradition, the lens with which to experience or see. For me it's just geographical. I mean, we're sort of what we are usually because of where we live or who our parents are.*

Mason similarly described religion negatively as concerning itself with creating divisions between groups, identifying spirituality more positively as something concerned with connectedness:

> *Every religion to me seems to have that extremism and that feeling that there's one group that's higher or superior to others and one group that has entry to heaven and the rest don't . . . . Spirituality I think has to do more with connections between people who are there and not there.*

Mason identified spirituality as a more capacious concept, with fewer codified rules and more room for individual experience.

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[9] Beverly Mason [pseudo.], interview by author, audio recording, 30 September 2010.

As difficult as religion is to define, spirituality may be an even harder concept to pin down. Articulating a feminine spirituality is particularly difficult, because, strictly speaking, to call a thing *spiritual* marks it as distinct from the bodily or material realm. The sharp separation between spirit and body, which is so damaging to an authentic spirituality of childbirth, is enshrined in the ethereal nature of the word *spiritual*. The word implies something incorporeal, distinct from the flesh. From the Latin, *spīritus,* meaning breath, the word *spirit* evokes the vitiating breath of life that God breathed into Adam and Eve in the Garden of Eden.[10] Medieval theologians codified a sharp division between body and soul that was largely absent from early Jewish and Christian thought. Along with this distinction came a radical devaluation of the body in general. Church fathers condemned sexual (and consequently reproductive) functions of the body especially, and tended to reserve their most vitriolic diatribe for the sexual and reproductive functions of women. In contrast to the base functions of the body, and the even baser functions of the woman's reproductive body, the word "spirit" eventually came to represent the disembodied soul, ethereal and immaterial that escaped from its corrupt vessel only at death, with the cessation of breath.[11]

This artificial separation between the spirit and the body can complicate an articulation of the experience of birth, a deeply embodied process that is spiritually significant. Eva Jacobs, a self-described atheist Jew, whose story of her hospital stillbirth I describe in detail in Chapter 6, put it this way:

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[10] *The Oxford English Dictionary*, 3d ed., August 2010; online version November 2010, s.v. "spiritual," "spirit."

[11] While breathing is now recognized as a bodily function, the cessation of brain activity now marks death in contemporary Western medical culture. This parallels a shift from soul-body dualism to mind-body dualism and a tendency to conflate consciousness with brain function.

> *In the moment of the birth I was so about my physicality—it was so just a physical experience. And it's not that a physical experience can't be spiritual or isn't spiritual, it's just that I think it's spiritual on either side of it. Part of the point of it is you lose your ability to have that mental level of thinking that for me defines spirituality. So many spiritual practices and religious practices are about pushing you into that space where you can't think and then coming out on the other side and interpreting it. [For example,] you fast for a day, so then you come out on the other side and you think, "Oh, I had such physical emotions and thoughts and now I am more in tune with the suffering of the world." Or you go through a trance dance until you are released from your ego and think, "I connect to everything." And there is a process in birth where that happens, where you are released from the world in some ways; you don't really know what's going on, you don't really know who's there, but you do, but you don't care. You're naked and it doesn't matter; and you're shitting on the floor and it doesn't matter. And that kind of release often brings spiritual insight afterwards; but I don't know if it, in and of itself, is spiritual. In and of itself [birth] is physical.*
>
> *Maybe I should back up and say here that I don't know if I believe in the divide between physical and spiritual as much as these words are forcing me to make. I don't know if I believe in that separation as strongly as this language that drives me to separate them.*

Jacobs struggles with the sheer physicality of birth: "You're naked and it doesn't matter; and you're shitting on the floor and it doesn't matter." At first she concludes that the spiritual insights, the "mental level of thinking that for me defines spirituality," can only happen in hindsight. However, she then revises her thoughts, suggesting that "the divide between physical and spiritual" is not something innate, but rather something that "these words are forcing me to make."

Among the women and providers I interviewed, an overarching distinction emerged: interviewees tended to associate religion with rules, order, doctrine, and group affiliation, where spirituality tended to be associated with individualized personal beliefs, social justice, transcendence, and individual expression, although subjects also emphasized connectedness. To that end, the women and providers I interviewed tended to validate Klassen's findings, elevating spirituality and finding it to be a better framework than religion for sacralizing childbirth. Midwife Barbara Stanford said:

> *Spirituality I think is for me an ability to connect, to feel deeply, to appreciate—I think appreciation is in there somehow but I'm not exactly sure how. And when someone says, "I feel blessed," I get that, too. I feel blessed, but probably not the same way they're saying it or meaning it . . . . Religion I see as a formal assignment, a group affiliation, and rules, and [I also view it as] somewhat inflexible and intolerant—that's another of off-putting thing to me, too. And I see religion as maybe being a little bit more magical thinking than what I'm comfortable with . . . . I see money with religion, and when I look at a big cathedral I may think, "Gosh, there's a lot of people we could have fed with that." And I realize you need a place to gather but it could be modest and be conservative for a purpose.*[12]

At the same time, many women I interviewed were religiously identified, and providers identified religion as an important source of meaning for patients. As Sarah Anderson told me:

> *I think religion is more doctrine and I think spirituality is just the spirit living in form . . . Religion is more of the structural, more the outer . . . the structure that holds a place to talk about the spirit. I think most religion doesn't really have too much to do with the founders, you know, for the vast majority of peoples in those religions. So I think they kind of get hijacked by other agendas . . . greed and power and disdain—religions are in large part hijacked by that. But I also think that they hold—within the world traditions anyway—the jewels of the truth if one's lucky enough to see or experience that. I wouldn't throw them out because I do think they hold the jewels of the truth of it. But I don't think they're the only keepers of that. I think that that's in life, that that can be found. It doesn't have to be religion. You can find that in life because that's what it is, it's life.*

Finally, many interviewees also suggested a connection between spirituality and religion and mentioned religion as one way among many to achieve spirituality. Obstetrician Melanie Saunders summarized this idea:

> *I think of religion as being more organized, and it has kind of an organized structure, and spirituality is . . . something that's . . . inside . . . like this feeling*

[12] Barbara Stanford [pseudo.], interview by author, audio recording, 25 July 2010.

> *inside . . . a sense of your connectedness in the world. Religion is a way of achieving a sense of spirituality, but there are many other ways.*[13]

Thus, despite the difficult history of both words, *religion* and *spirituality*, contemporary women and providers continue to use both of them to describe the embodied experience of childbirth. Interviewees gave a range of definitions of these two terms. Given that range and given a general consensus that religion pertains to the organized practice of specific groups, while spirituality is the sense of connectedness that underlies religious practice, a non-essentialist definition of both words along the lines of Wittgenstein's model of family resemblances is a good starting point for this project.

MAGIC AND RELIGION

> *Women . . . are everywhere recognized as being more prone to magic then men, not so much because of their physical characteristics, but because of the social attitudes these characteristics provoke. The critical periods of their life cycle lead to bemusement and apprehension, which place them in a special position. And it is precisely at periods such as puberty, menstruation, pregnancy and childbirth that a woman's attributes reach their greatest intensity. It is usually at such times that women are supposed to provide subjects or act as agents for magical action.*
>
> -Mauss and Hubert, *A General Theory of Magic*, 1904. [14]

Two prominent scholars in the social sciences of religion, James Frazer and Emile Durkheim, relied on a dichotomy between religion and magic in their studies of religion. Frazer views religion as a faith in deities who rule the natural world, characterizing magic as a more primitive belief in the mystical powers of similar objects to influence each other. Durkheim focused on an intellectual conception of the sacred as the defining feature of religion, meanwhile characterizing magic in terms of individual attempts to change the natural world. These theories have been criticized from a cultural perspective

[13] Melanie Saunders [pseudo.], interview by author, audio recording, 30 August 2010.
[14] Mauss and Hubert, *A General Theory of Magic*, 35.

for their problematic belief in the superiority of monotheism and their characterization of non-Western religious systems as primitive and therefore inferior. More recently, attention has been paid to the problems this dichotomy creates for women's spiritual experience. In the mid-1980s, Robert J. Fornaro cautioned against the traditional dichotomy between religion and magic in the social sciences, suggesting that it has detrimental consequences to women's religious practices. Fornaro relies on Lucienne Roubin's term *women's space* to describe religious practices that have uniquely feminine elements and argues that the association of women's religious practices with magic rather than religion has resulted in an underestimation of the extent and importance of women's space in religion.[15]

In particular, Fornaro focuses on the tendency to link women to magic in negative ways, for example in the context of witchcraft. The result is a stigmatization, marginalization, and invalidation of women's embodied experience. He writes:

> The most obvious sources of innate supernatural power in women are those endemic to feminine physiology and biological function. It is these attributes, and they are attributes when charged with supernatural power, that beg the paradigm of women's space in religion. They provide women with an innate reservoir of supernatural power. To understand this is to elevate women to the status of a unique spiritual resource, vital to religion and culture.[16]

Fornaro argues that the dichotomy between religion and magic traditional to sociology and religious studies is harmful to a full understanding of the importance of women's space in religion. Women's religious practices are often maligned as magic, particularly when they are related to women's procreative function. This dismissal of the religious elements of women's religious practice in general, and specifically supernatural elements

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[15] Robert J. Fornaro, "Supernatural Power, Sexuality, and the Paradigm of "Women's Space" in Religion and Culture," *Sex Roles* 12, no. 3 (February 1, 1985): 295-302.
[16] Ibid., 297.

of women's procreative functions, contributes to a marginalization of religion in childbirth.

Gregg Lahood expands on this stigmatizing association of women's sacral power with negative aspects of magic.[17] He describes examples of births in non-Western contexts in which spirits can assist with childbirth, often by possessing the midwife who may function as a medium. Both Lahood and Sered point to a male/female dichotomy in healing practices: while male shamans tend to travel skyward to the spirit realm, women healers are more likely to function as embodied mediums for possession by spirits. The receptive, inward mysticism of possession that characterizes some non-Western midwifery practices is far more stigmatized than the outward spirit journey of a male shaman. Particularly in the West, the receptive mode of mysticism was condemned by the two major Western religions, Judaism and Christianity, most prominently during medieval witch-hunts. Lahood refers to this historical process as a "demonization of spirit possession."[18] Since spirit possession was associated with women healers in general, and midwifery practice specifically, the demonization of spirit possession had disproportionately negative effects on spiritual aspects of birth. The pejorative condemnation of indigenous religious systems as "magic" or superstition is certainly problematic. But for women's magico-religious practices, the idea of demon possession adds an element of fear and negativity. A curiously condescending attitude approach towards male shamanism becomes a fearful assumption of malevolence when applied towards female magic, or witchcraft.

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[17] Gregg Lahood, "Rumour of Angels and Heavenly Midwives: Anthropology of Transpersonal Events and Childbirth," *Women and Birth: Journal of the Australian College of Midwives* 20, no. 1 (March 2007): 3-10.
[18] Ibid.

The removal of supernatural practices surrounding women's procreative functions from the purview of religion practices, and the further demonization of magical practices associated with women, contributes to the double stigmatization around religion in childbirth. As religion's role in healing practices generally declined with medicalization of illness and birth, religious healing systems took a backseat to scientific medical practices and became stigmatized. In childbirth, this decline of the importance of religion in medicine was reinforced by a pre-existing stigmatization of the religious practices associated with birth as magic, witchcraft, and even demon possession. As Klassen points out, even before modern Western religions "abandoned childbirth . . . to medicine,"[19] they had already rejected it as a polluting force in religion, sullied by superstition, magic, and even demonic possession.

The gendered dichotomy between magic and religion persists today, both literally and in the form of a gendered valuation of *religion* over *spirituality* in academic circles. Klassen reports that among her subjects, even religious women often identify birth as spiritual rather than religious. She writes, "Many of the women in my study preferred the term spirituality to religion in the case of childbirth, and in many cases derided religion as superficial (even when they claimed religious affiliations themselves)."[20] As we saw in section one, my interviewees similarly tended to devalue religion in birth, which they often characterized as divisive, rigidly structured, and hostile to women, while elevating spirituality, which they associated with connectedness and individual experience. Oddly, the reverse is often true among the remaining academics who do study the numinous, usually theologians and religious-studies scholars. While both birthing women and

[19] Klassen, *Blessed Events: Religion and Home Birth in America*, 83.
[20] Ibid., 82.

maternity-care providers value spirituality over religion, particularly for describing birth, academics tend to elevate religion over spirituality.

The stigmatization of women's space in religion puts Klassen, an academic studying religious practices, in an interesting position. Even as the women in her study often derided the term *religion* as an inadequate and superficial descriptor in terms of childbirth, she often felt obliged to refer to their practices in terms of religion because of the traditional tendency among academics and theologians to place value on religion over spirituality. She writes: "Remembering that 'religion' is a constructed category used to value some kinds of activity and devalue others, I often use the term religion when describing these women's actions in my own voice because I want to emphasize that home birth fits within what scholars have studied as religious practice."[21]

Sered also describes how the marginalization of women's space in religion creates difficulties for religious women attempting to describe a sacred experience of birth. In her work interviewing Jewish women in Israeli hospitals, she describes many women who denied that their birth experiences were religious, or even spiritual, even though "they were actively interested in rituals to protect their babies, and they consistently described the developing relationship with their babies as miraculous." She continues:

> Aspects of religion that are normally emphasized by anthropologists . . . seem at most peripheral to the kind of religion described by the women. For them, "miracles" have to do with a specific, known baby for whom a specific woman has accepted the responsibility of caring. "Religion"—formal Jewish observances and mystical experiences—was deemed by most women to be irrelevant to their childbearing experiences.[22]

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[21] Ibid.

[22] Susan Starr Sered, "Husbands, Wives, and Childbirth Rituals," *Ethos* 22, no. 2 (June 1994): 12.

Like Sered, Klassen found that, in contrast to academics and theologians, "women's preferences of terms are inverted: religion is more 'real' than spirituality, perhaps because it has a longer and more distinguished—though increasingly compromised—pedigree."[23] That women in both studies overwhelmingly did not identify their births as religious experiences is tied to the devaluation of women's space in religion Fornaro outlines.

Furthermore, in Western monotheism, beyond simple abandonment of feminine supernatural power, some religious law actively stigmatizes women's biological and procreative functions. These biological and procreative elements are the aspects of femininity that Fornaro described above as "the most obvious sources of innate supernatural power in women."

Klassen suggests that one of the reasons women eschew the term religion to describe their birth experiences is a historical tendency in Western religions to associate women's bodies in general, and childbirth specifically, with pollution and ritual uncleanness. Keeping this tendency in mind, advocating for the importance of religion or spirituality in pregnancy is not without danger. Associating pregnancy and birth with magico-religious ritual can also have damaging consequences for women. Putting aside for a moment the possibility for physical morbidity or mortality associated with pregnancy-related rituals, many of the rituals surrounding birth and menstruation in *both* Western and non-Western cultures serve to stigmatize women's embodiment. Obstetrician Anne Drapkin Lyerly says of birth:

> It is a locus to which women bring a lifetime of experiences relating to the shame of female embodiment: of demeaning treatment and subordination, of traditions

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[23] Klassen, *Blessed Events: Religion and Home Birth in America*, 83.

> that relate female sexuality to pollution and contagion, and of expectations about what a good woman and good mother should be capable of doing.[24]

The idea that women's biological functions create ritual danger or impurity exists in both Western and non-Western magico-religious traditions. Both Sered and Klassen point to the labeling of birth as impure by the major Western religions as one of the reasons the women in their studies rejected the term *religious* to describe their births. The following section will address ways in which the traditions of the majority of religious systems available to women giving birth in American hospitals, most of them associated with Western monotheism, marginalize the sacred in childbirth.

THE DEVALUATION OF WOMEN'S SACRAL EXPERIENCE IN WESTERN MONOTHEISM

In addition to the marginalization of women's spiritual and sacred practices that results from their categorization as magic, there is also a longstanding tradition within Western monotheism that devalues women and their bodies. In all three Abrahamic traditions, monotheism typically means the exclusive worship of a masculine deity. As such, it has been a major focus of criticism among many Western feminists who argue that the Abrahamic religions not only marginalize women's social and religious functions, but also deemphasize feminine spirituality. Karen Armstrong, for example, characterizes the oppression of women in the name of religion as "[o]ne of the great flaws of monotheism."[25] She writes, "Each of the three [Abrahamic traditions] has pushed women into an inferior and marginal position, excluding them from full participation in the social, cultural, and religious life of the community."[26]

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[24] Anne Drapkin Lyerly, "Shame, Gender, Birth," *Hypatia* 21, no. 1 (2006): 111.
[25] Karen Armstrong, "Foreword," in *Daughters of Abraham: Feminist Thought in Judaism, Christianity, and Islam*, ed. Yvonne Haddad and John Esposito (Gainesville, FL: University Press of Florida, 2002), vi-vii.
[26] Ibid, vii.

In terms of female life-cycle events, particularly birth and menstruation, scholars point to a tendency towards marginalization, stigmatization, or both within the Abrahamic traditions.[27] In Judaism, menstruation and birth are both subject to halakhic restrictions that characterize women as unclean.[28] Christianity has historically stigmatized women's bodies, particularly in their sexual capacities, acknowledging the importance of maternity, but often viewing virginity as a higher calling.[29] In Islam, women are forbidden from performing ritual prayers or touching the ka'bah at pilgrimage during menstruation or post-natal bleeding.[30] Even more problematic for women who associate a positive spiritual element with the experience of pain during childbirth, the book of Genesis characterizes painful labor as one of the punishments to which God subjects Adam and Eve after their disobedience in the Garden of Eden.

Judaism and Christianity share a historical association of women's bodies with sin and shame, particularly so in their reproductive capacity.[31] Monotheism is often seen as enshrining gender hierarchies in divine law, naturalizing oppression of women, and, through a process of false consciousness, limiting any potential for change from women themselves. Simone de Beauvoir summarizes:

> Man enjoys the great advantage of having a god endorse the code he writes; and since man exercises a sovereign authority over women it is especially fortunate that this authority has been vested in him by the Supreme Being. For the Jew, Mohammedans, and Christians, among others, man is Master by divine right; the

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[27] Carol Christ, *She Who Changes: Re-Imagining the Divine in the World* (New York, NY: Palgrave Macmillan, 2003); J. G Raymond, "Medicine as Patriarchal Religion," *Journal of Medicine and Philosophy* 7, no. 2 (1982): 197; Kathryn Rabuzzi, *Motherself: A Mythic Analysis of Motherhood* (Bloomington, IN: Indiana University Press, 1988).

[28] Sered, "Childbirth as a Religious Experience?."

[29] Cristina L. H. Traina, "Maternal Experience and the Boundaries of Christian Sexual Ethics," *Signs* 25, no. 2 (Winter 2000): 369-405.

[30] Shaikh Muhmmad bin Jamil Zeno, *The Pillars of Islam and Iman* (Houston, TX: Darussalam, 1996).

[31] Jonah Steinberg, "From a "Pot of Filth" to a "Hedge of Roses" (And Back): Changing Theorizations of Menstruation in Judaism," *Journal of Feminist Studies in Religion* 13, no. 2 (1997): 5–26.

> fear of God will therefore repress any impulse to revolt in the downtrodden female.[32]

In addition to the broader anti-feminist sentiments engendered by traditional monotheism, Christianity and Judaism have associated women's bodies and reproductive capacities in particular with sin and shame. This means that, in terms of spiritual and religious approaches to birth, Abrahamic monotheism often seems particularly ill-suited to the needs of women. Nurse Diane Lauver, writing about women's spirituality and women's health, argues that traditional religious approaches to women's health are often inadequate because of an assumption that bodily functions, which women appear more tied to than men, have been culturally constructed as a sign of inferiority. She writes:

> God has been seen as superlative to man, and man as superlative to women and animals. Women have bodily functions such as menses, birth, and breastfeeding that are shared with mammals, but not men. To the extent that bodily functions are lesser in value, and that women are associated with bodily functions, then women are presumed to be inferior to men.[33]

In Christianity in particular, the association of sex with shame in the Christian church culminated in a climate in the middle ages in which Church fathers, elevating celibacy and chastity, denigrated women's bodies in their writing. De Beauvoir describes:

> The flesh for the Christian male is the enemy Other and is not distinguished from woman. The temptations of the earth, sex, and the devil are incarnated in her. All the Church Fathers emphasize the fact that she led Adam to sin. Once again, Tertullian has to be quoted: "Woman! You are the devil's gateway. You have convinced the one the devil did not dare to confront directly. It is your fault that God's Son had to die. You should always dress in mourning and rags." All Christian literature endeavors to exacerbate man's disgust for woman. Tertullian defines her as "*Templum aedificatum super cloacum*" [the temple on the sewer].

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[32] From, Carol Christ, "Why Women Need the Goddess," in *Womanspirit Rising*, ed. Carol Christ (San Francisco, CA: Harper SanFrancisco, 1979).
[33] Diane Lauver, "Commonalities in Women's Spirituality and Women's Health," *Ans. Advances in Nursing Science* 22, no. 3 (March 2000): 76-88.

> Saint Augustine points out in horror the proximity of the sexual and excretory organs: "*Inter faeces et urinam nascimur*" [We are born between shit and piss].[34]

The association of Eve with sin and shame from the Genesis story influenced Church doctrine in its enshrining of a negative view of women's reproductive organs. This culminated in a climate wherein virginity was prized above maternity. Religious studies scholar Cristina Traina suggests that birth's inherent association with sexual intercourse marred Western theology's approach to birth, writing:

> Pre-reformation Western theologians are nearly united in their opinion that, all things being equal . . . virginity is a higher calling for women than maternity . . . Although mothers virtuously fulfill the divine command to bear children, maternity is also a visible and constant reminder of the irrational, passionate character of even procreative intercourse.[35]

Traina goes on to place the Virgin Mother at the pinnacle of this paradox. Although some contemporary scholars see Mary as an important representation of the feminine divine, she also represents an unattainable ideal whereby a woman can fulfill the commandment to be fruitful and multiply without the shameful associations of sexual intercourse.

Neither does birth itself escape a negative association with women's genitals. We are born, as Augustine points out, "*Inter faeces et urinam*." Beyond an aversion to the close association of birth with sexual intercourse, childbirth itself was viewed by church fathers as problematic because it constituted a possible violation of Mary's perpetual virginity. De Beauvoir writes, "Christianity's repugnance for the feminine body is such that it consents to doom its God to an ignominious death but saves him from the stain of birth."[36] She is referring to a belief, best articulated by Augustine of Hippo, that

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[34] Simone de de Beauvoir, *The Second Sex, 1949*, trans. Constance Borde and Sheila Malovany-Chevallier (New York, NY: Random House, 2002), 186.
[35] Traina, "Maternal Experience and the Boundaries of Christian Sexual Ethics," 378.
[36] de Beauvoir, *The Second Sex*, 186.

distinguishes the Virginal Birth from the Virginal Conception, adding to the idea that Jesus was *conceived* without sex a second precept that the Nativity itself was miraculous, occurring (ostensibly extra-vaginally, though the anatomic descriptions are oblique) without violating Mary's virginity. Augustine, for example, writes in one of his letters that a mysterious "power brought forth the body of the infant from the inviolate virginal womb of the mother, as afterward the Body of the Man penetrated closed doors."[37] In the fourth century, Ambrose, likewise suggested that Christ was born miraculously, leaving Mary's hymen intact. He writes, "When He was born from His mother's womb, He yet preserved the fence of her chastity and the inviolate seal of her virginity."[38]

Even leaving aside the issue of overt stigma and shame associated with sex and birth, one still notices a paucity of specific religious rites and rituals associated with women's reproduction in Western monotheism. Though they are common in many cultures, Christianity and Judaism lack specific religious rituals to celebrate menarche or mark birth. For example, although there are special rituals surrounding newborn babies, such as baptism and ritual circumcision, officially sanctioned religious rituals that take place during or immediately after childbirth itself are rare in traditional forms of Judaism and Christianity. Sered has suggested that patriarchal control of church functions led to a dearth of specific religious rituals at birth.[39] Since birth was historically a female-only space, and religious officiants could only be male, rituals surrounding birth could not be actively adopted or performed by the religious clergy.

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[37] Philip Schaff and Henry Wace, *A Select Library of Nicene and Post-Nicene Fathers of the Christian Church: St. Ambrose: Select Works and Letters* (New York, NY: The Christian Literature Company, 1896), 461.
[38] Ibid.
[39] Sered, "Husbands, Wives, and Childbirth Rituals."

In light of the dearth of existing religious ritual and the shame and stigma associated with women's bodies in Western monotheistic religions, it might seem reasonable to assume that these religious traditions are inadequate to the task of sacralizing childbirth. But rather than arguing that this lack of specific rituals made women unable to interpret birth religiously, Sered suggests that women acknowledge the sacral aspects of birth, even in the midst of religious systems that are generally patriarchal. She writes:

> It is axiomatic to feminist analysis that even within the context of patriarchal culture, women also create religion; that women cross-culturally are involved with beliefs and rituals that reflect and enhance their experiences, dramatize their dilemmas and desires, contribute to the resolution of their problems, and sacralize their everyday lives.[40]

As Sered has suggested, women in birth continue to "create religion," using existing narrative structures to sacralize their experiences and drawing on their own experiences to reinterpret existing texts and infuse metaphors with new meaning.

MORAL BRICOLAGE AND HOSPITAL BIRTH AS SACRED EXPERIENCE

> *[The midwife] had suggested we all kind of pray and just thank God—whichever god was out there—for being a part of that chain of love instead of being a chain of abandonment, and labor progressed and she had a really great birth . . . I think you can't escape spirituality. I think how we care for people's spirits in births is important and something that we should be aware of. Because it's definitely a component that can have some real physical ramifications.*[41]
>
> -Renee Miller, Doula

Pamela Klassen has referred to a practice she calls, "procreating religion," by which women "make religious meaning out of the embodied memories and human

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[40] Sered, "Childbirth as a Religious Experience?," 7.
[41] Renee Miller [pseudo.], interview by author, audio recording, 4 May 2010.

connections forged in the process of childbirth."[42] Klassen's compelling work on home birth suggests that, despite a marginalization of the sacred in birth both from the medical establishment and from the major Western religious traditions, women continue to actively ritualize, experience, and narrate birth as a sacred event. For home birthing women, the sacral power of birth to evoke spiritual and religious experience cannot be entirely subsumed by a patriarchal system, either medical or religious.

I would like to build on Klassen's argument by suggesting that it is not just home-birthers, but also hospital-based maternity care providers and the women they care for, who "procreate religion" in their experience and narration of hospital birth. By doing so, these women are doing important moral work in a pluralistic medical culture. Philosopher Jeffery Stout, in his book *Ethics After Babel,* has suggested that a fundamental act of moral thinking in modernity is what he terms "moral bricolage," a process by which traditional moral narratives and language are made relevant to contemporary moral problems.[43] According to Stout, it is hopeless to try and create a "moral Esperanto," since religious language is the major source of extant moral language.[44] Rather than jettisoning traditional religious language from contemporary moral discourse, as many scholars have suggested, Stout argues that we must instead draw on traditional narratives and metaphors in innovative ways, laying them together to meet the needs of contemporary society.

Because they often draw on images, symbols, and allegories from a diverse array of moral and ritual traditions, medical, religious, and secular, hospital birth stories often

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[42] Klassen, *Blessed Events: Religion and Home Birth in America*, 63, 64.
[43] Jeffrey Stout, *Ethics After Babel: The Languages of Morals and Their Discontents* (Princeton, NJ: Princeton University Press, 2001), 292.
[44] Ibid., 74.

demonstrate this principle of moral bricolage. These stories bring together disparate moral languages, rituals, and traditions, and recontextualize them in a way that makes them relevant to the needs of contemporary maternity care. In my interviews, providers and patients often used imagery and metaphor from religious and moral traditions they identified themselves as being part of, but they also drew on myths, symbols, and images from religious traditions with which they themselves did not identify. For example, doula Jane Rogers spoke about attending and giving birth through the Christian metaphor of baptism, even though she does not identify with any specific religious tradition. She said:

> *Both witnessing birth and giving birth, it is so much aligned with this otherworldly holy existence. I don't consider myself religious in any way, but when I gave birth, I absolutely felt as if I had been [baptized]. It felt like being baptized. And I do not align myself with that idea at all, and yet when I say that word I think people get what I'm talking about they, they get the profoundness.*[45]

Through this practice of moral bricolage, health care providers were able to approach spiritual and religious aspects of maternity care even while they were attending to a religiously diverse patient population. In the process they were able to integrate their own diverse spiritual and religious influences into a medical culture that situates ultimate value in objective knowledge.

Because of the longstanding association of women's bodies with shame and sin, some feminist scholars, including Carol Christ, have suggested a retreat from monotheism into religious systems such as goddess-centered spirituality that emphasize the divine aspects of the feminine. Particularly where childbirth is concerned, Christ argues that the Abrahamic traditions are hopelessly inadequate to the task of sacralizing childbirth.[46] Goddess-centered spirituality does play a role in sacralizing birth for many

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[45] Jane Rogers [pseudo.], interview by author, audio recording, 15 June 2010.
[46] Christ, "Why Women Need the Goddess."

women (this may be especially true for home birthing women and midwives).[47] However, women who identify with Abrahamic religions also interpret childbirth as sacred within the framework of patriarchic monotheistic religion. Furthermore, from the perspective of providers who must care for women from majority religious backgrounds, the ability to acknowledge a spirituality of birth in the context of Western monotheism can be critical.

The importance of acknowledging religion and spirituality in maternity care for patients from minority religious backgrounds with which providers are less familiar may seem self-evident. Less commonly discussed, however, is the importance of spiritually respectful care for women from majority religious and cultural backgrounds, or for secular women. Attention to spiritual care in obstetrics can be challenging even when both provider and patient identify with a similar belief system. The providers I interviewed were often forced to navigate differences in religious belief between themselves and their patients even in seemingly simple cases where both identified as Christian. Franklin, for example, spoke about the tension apparent when approaching issues of religion in maternity care:

> *Even if you both are of the same religion you still may have differing views within that religion about contraception or end of life issues. And from a doctor's perspective, I think sometimes it would be inappropriate to try to broach that subject or bring that up. But then on the other hand, since I am still religious, or not religious, but spiritual, if a patient asks me to pray with them, then I'm willing to do that.*[48]

Remarking further that "the patient has to initiate that kind of interaction," Franklin pointed both to the difficulty of negotiating religious aspects of care in his increasingly

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[47] Klassen, *Blessed Events: Religion and Home Birth in America*.
[48] Austin Franklin [pseudo.], interview by author, audio recording, 25 May 2010.

religiously pluralistic patient population, as well as the importance of engaging patients on religious terms when they desire such interaction.

Providers often have to navigate tensions between their own religious belief systems and those of their patients. Clarkson's urban midwifery practice serves mainly Spanish-speaking immigrants—as an evangelical Christian, she considers her midwifery practice part of her religious duty to serve the poor. Still, she describes engaging in practices with her patients that diverge from her stated religious beliefs:

> *Sometimes you do things that stretch your own religious comfort. I come from a background where we don't baptize children, we wait for them to make their own spiritual choice, but if a patient asks me to baptize a baby, I will do it. Not because I believe in it, but because the patient wants me to.*[49]

Clarkson's religious beliefs motivate her midwifery practice, yet she is able to participate fairly fluidly in religious ceremonies that are different from, and even discouraged by, her own religion.

Clarkson also described the experience of attending an in-hospital Catholic ceremony for a baby she delivered who died before birth:

> *There was a liturgy, and there were psalms that were recited after the baby was born and the baby was baptized immediately at birth. And I joined in with it—some of the responses I didn't know, I'm not Catholic. The 23rd Psalm, the Lord's Prayer, I know those. I joined in. It was powerful. Tearful, sad. The baby had died. We had no answers, [though] we did eventually. Not everybody is comfortable doing that, but I am. It was important to do it. I think to just walk out when that was happening . . . It was very important to the family. I had just delivered this baby. To just say then, 'that's not my problem,' that wouldn't have been right.*

Though she does not identify as Catholic, and even disagrees with many Catholic teachings, Clarkson felt that, as a midwife, her moral obligation to her patient outweighed

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[49] Alyssa Clarkson [pseudo.], interview by author, audio recording, 14 February 2010.

any discomfort she might have had with participating in a Catholic ceremony. For Clarkson, the bond created by delivering a baby necessitated participation in the religious ceremony that followed, even if doing so required both compromise and improvisation—for example, joining in when she knew the words.

Doula Renee Miller spoke about the vulnerability of patienthood in religious terms:

> *I've seen lots of women being treated really poorly in regards to prenatal care and birth and post partum, and the part of me that feels like Christ calls us to care for the least of these . . . it's not always people who are financially or socioeconomically in need, but groups who are neglected. And I feel that women definitely deserve to have somebody champion for them in birth and as new mothers . . . Regardless of whatever spiritual beliefs they have, it's kind of like God's work, caring for people who are at a really vulnerable place in their lives.*[50]

Miller identifies as a Christian, but she is able to use her religious beliefs as a motivation for providing humane maternity care to women from all religious and spiritual backgrounds. In fact her motivation to become a doula began with a first birth experience caring for a Wiccan woman. She related the story:

> *One dark and stormy night our nurse who assisted our midwife was unable to make it there in a really speedy fashion. And I went back to our birth house to check and see if anybody needed anything and they said, yeah, we could use a doula. Well I wasn't a doula and I was definitely wearing like a pencil skirt and heels and I ended up hopping into a tub with a mom who's actually—this was interesting—a Wiccan who had other women who she practiced with there and they were very excited when we walked into the room because it made it number thirteen—lucky number thirteen—so they were very overjoyed about that whole situation . . . And so I thought okay, sure I can do this and just with a little guidance from our midwife who was able to help her, support her in the process, actually like literally hold her up in a tub of water for the birth of her baby girl. So from that moment on I was hooked and explored doula training further.*

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[50] Renee Miller [pseudo.], interview by author, audio recording, 4 May 2010.

Miller, an Evangelical Christian who practices as a hospital doula, was inspired to pursue doula training through her interaction with a home birthing Wiccan woman. Miller's story points to the importance of moral bricolage in articulating an experience of the sacred in hospital birth.

These are just a few examples of how providers and the women they care for continue to "procreate religion" in the pluralistic hospital environment. The following four chapters will explore in detail narratives in which providers and the women they care for resist the desacralizing thrust of allopathic medicine as well as the stigmatizing elements of patriarchal religious systems.

SECTION II: PROVIDER PERSPECTIVES

Chapter 3:

From the Obstetrics Case History to the Clinical Tale in Birth: *Provider Perspectives on Narrative, Spirituality, and Obstetrics*

> *A sequence of experiences can only be a meaningful sequence if they are ordered and reordered according to some overarching theme. Frequently, these themes are drawn from culturally available and acceptable . . . genres or myths.*
>
> -David Yamane, "Narrative and Religious Experience," 2000

> *I tell these stories over and over and over again. . . . I think that there is so much wisdom in the story. I can say to you, birth is a spiritual experience, death is a spiritual experience. Great. And it sounds good, but the story depicts it in a way that [nothing else can] . . . I can't teach it without the story. The story brings in the emotional components, the intellectual components. It brings it all together.*
>
> *-Patricia Woods, MD*

Karina Neiman is an obstetrics and gynecology intern in her first year of residency at a large urban teaching hospital. Nieman has a master's degree in medical anthropology, which she completed before finishing medical school. She has worked with traditional Mexican birth attendants as both a researcher and an advocate for integrating traditional birth attendants into hospital birth in Mexico. I interviewed Nieman on the recommendation of a local doula, and when I asked her how she felt spirituality was related to obstetrics as it was practiced in hospitals, she responded, as many of the providers I interviewed did, with a narrative:

> *I still have my birth story that I get really emotional about. I was an L and D [labor and delivery] intern in July . . . . I had delivered four or five babies [before becoming an intern]. Now I'm the doctor, and God knows what the hell I was*

> *doing. The head of our department is an REI guy who does abdominal cerclages . . . there are only 3 or 4 people in the country that do these. You basically stitch the internal os.*[1] *And you have to have a c-section: there is no vaginal delivery. These are people who have tried so hard to have babies.*
>
> *[This patient] went into labor on the same day that her cesarean was scheduled . . . I didn't do her c-section, but I went in to see her in recovery . . . . Literally it was one of those [moments], like when you have your jewelry box, your little box of memories, and that's my little trinket that when I open it I think about it . . . . She's in the recovery room and she just has this look on her face like, "I fucking did this," looking at this baby and he's looking up at her and I was just . . . She was just like, "Finally! I finally have this baby." This was clearly the mom's happiest moment of her life, and she's just radiating. Clouds are parting, angels are singing. It's one of those beautiful moments. And I thought, "This is why I do this. Because I get to see this. That is why I do this." No matter how fucking shitty it gets, and it does get shitty, it gets so shitty . . . I don't really know what I mean when I say spirituality, but I think . . . it's the moment of pure joy. That moment.*[2]

As a narrative about spirituality in hospital birth, Nieman's story is surprising on multiple levels. In the first place, the narrator is an obstetrics and gynecology intern, a member of a group notorious in anthropology and sociology literature for ignoring and even impeding spiritual aspects of birth. Furthermore, the phrase "spirituality in childbirth" generally evokes an image of a gentle home birth, perhaps involving candles, and a birth tub, and certainly with little to no medical intervention. From that perspective, given the narrator's background in anthropology studying midwives, you might expect her to narrate a story about a natural birth. In stark contrast, the story Nieman chose as an example of spirituality in birth involves abdominal cerclage, an extremely high-tech medical intervention that mandates cesarean section. Even more surprisingly, although

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[1] The cervix has two openings: the internal os, inside the vagina, and the external os, the entrance to the uterus, which is located inside the pelvic cavity. Cervical cerclage is a fairly common procedure for women who have had multiple miscarriages due to premature cervical dilation. In a typical cervical cerclage, an obstetrician puts a stitch in the external opening of the cervix, called the external os, to try and prevent premature cervical dilation and labor. Abdominal cerclage is a very rare, experimental procedure in which the internal os is stitched via pelvic surgery.

[2] Karina Nieman [pseudo.], interview by author, audio recording, 17 February 2010.

Nieman is an atheist, her story not only evinces a recognition of spirituality as an important part of birth, it also uses Christian religious metaphors (clouds parting, angels singing) to describe the central moment. Finally the "moment of pure joy" that Neiman describes occurs, not during the flashy cerclage surgery itself, or even during the cesarean section, which Nieman did not perform, but rather in a simple moment of human compassion during post-partum hospital rounds. The story is raw, riddled with obscenity, and even religiously irreverent. Her only use of the word "God" is in the profane description of her own perceived incompetence, "God knows what the hell I was doing." Yet for Neiman, the story evokes an image so powerful and sustaining that she keeps it as a memento in a mental "jewelry box . . . a little box of memories," to be opened and treasured during the more grueling parts of her residency training.

Medicine, as a largely narrative practice, has not only a unique lexicon, but also its own styles and genres. As Kathryn Montgomery Hunter has pointed out, oral case presentations, patient charts, and written case reports are all narrative genres with specific forms and conventions.[3] Similarly, contemporary obstetrics has its own genres: obstetrics case presentations, patient charts, and case histories are the backbone of clinical knowledge and communication in obstetrics.[4] Part of the draw and surprise of Nieman's story is that it diverges radically from the formal, rigid structure of these obstetrics genres, which strive towards objectivity and ordered thought. Though she almost certainly had to construct an obstetrics case presentation about the patient she described

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[3] Kathryn Montgomery Hunter, *Doctors' Stories: The Narrative Structure of Medical Knowledge* (Princeton, NJ: Princeton University Press, 1991).

[4] I use the term *obstetrics* here in its broad sense to refer to the clinical, hospital-based care of women during pregnancy, birth and the puerperium. This definition encompasses hospital-based midwifery care, and obstetric care provided by family practitioners. These providers all rely on case reports, patient charts, and written case histories to diagnose, treat, and communicate information about their patients.

above, the story that Neiman savors in her "jewelry box . . . of memories"—the story that sustains her through the trial of an obstetrics residency—is a very different kind of story. It is from a different genre. Existing somewhere between the case history and the first-person birth story (a genre I will discuss in detail in Chapters 5 and 6), Nieman's narrative can be best described in the words of neurologist Oliver Sacks. It is a "Clinical Tale," a story about a patient that simultaneously describes the affective and objective dimensions of a clinical encounter (in this case a birth rather than an illness).[5]

Attention to the role played by narrative in obstetric practice helps explain why religious and spiritual aspects of hospital-based maternity care are consistently marginalized in discourse pertaining to obstetrics. Through my conversations with 25 hospital-based maternity care providers, I have found that although maternity-care providers tell narratives all day, every day (narrative being the cornerstone of all medical practice), the conventions of available genres are limiting, particularly when it comes to describing the spiritual or religious significance of a birth. Intentionally selecting for providers who identified religion or spirituality as an important aspect of childbirth, I sought to examine professional practices that emphasize spirituality or religion as an important aspect of maternity care. Looking at the stories that these obstetrician gynecologists, family medicine physicians, certified nurse midwives, and doulas with hospital experience tell when they are not forced to conform to a clinical genre is enlightening. Their "Clinical Tales" provide a useful foil to the existing body of childbirth literature that overwhelmingly portrays hospital birth providers as emotionally distant and blunted to the importance of childbirth as a spiritually significant event.

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[5] Oliver Sachs, "Clinical Tales," *Literature and Medicine* 5 (1986): 16-23.

Focusing on birth narratives from maternity-care providers who work in hospitals, this chapter will begin by making the case for a narrative approach to studying spirituality in obstetrics. I will examine the most common narrative genre available to hospital-based providers, the obstetrics case history, showing that this genre serves the interests of maternity care providers and their patients in many ways, but also fails to provide a framework for articulating spiritual or religious experiences of birth. Next, I will show how hospital-based maternity care providers embrace novel genres like the clinical tale to articulate experiences of birth as spiritually and religiously significant.

BIRTH STORIES, CASE REPORTS, AND CLINICAL TALES

A narrative is a story that orders and recounts a series of events. Narratives can be either fictitious or factual, and they often span the gap between fact and fiction. In the various forms of allegory, parable, myth, and history, narrative plays an essential role in the construction of meaning. Storytelling is one of the primary ways that humans make sense of lived experience. As philosopher Ron Carson suggests, "Stories, with their beginnings, middles, and ends, redeem life from contingency and make it something other than a meaningless succession of events."[6] The word *narrative* is derived from the Latin *narrāre,* meaning, "to relate, or recount," but it is also closely related to the word *gnārus* and the root *gno,* which means, "to know."[7] To tell a story about something is a way of acquiring knowledge about that thing, and the type of story told, the genre, often determines what kinds of knowledge will be valued and prioritized. While this is certainly true in medical practice, it is more accepted in the realms of religion and

[6] Ron Carson, "The Moral of the Story," in *Stories and Their Limits: Narrative Approaches to Bioethics* (New York, NY: Routledge, 1997), 233.
[7] *The Oxford English Dictionary*, 3d ed., August 2010; online version November 2010, s.v. "narrative," "narrate."

spirituality, where metaphorical and allegorical thinking are openly acknowledged as legitimate ways of knowing.

Midwives and doulas associated with home birth are likely to acknowledge this direct link between narrative and knowledge. The contemporary home-birth midwifery movement had its origins in the same climate that birthed the women's health movements of the 1970s. Suspicious of medical institutions, which were largely controlled by men, and which often grossly misconstrued the reproductive and sexual aspects of women and their bodies, many second-wave feminists valued women's stories about their own bodies as a legitimate epistemology of the body. For example, the Boston Women's Health Collective, a group of women who penned the groundbreaking, do-it-yourself women's health manual *Our Bodies, Ourselves,* believed that in areas of sexuality and reproduction, women's stories often formed a superior epistemological framework to that embraced by patriarchal gynecology. Among home-birth midwives, this attitude often persists today: in many home-birth circles, the birth story is respected as a prime source of authoritative knowledge in childbirth. Birth stories inform home-birth midwifery practice in matters ranging from spiritual and religious experience to physiological knowledge about birth and the body. To begin to grasp the scope of this phenomenon, notice that the majority of the famous midwifery manual *Spiritual Midwifery* is comprised of women's own accounts of their spiritual experiences in birth. In terms of sacralizing birth, narrative is paramount: among home-birth midwives today, the first-person birth story is *the* time-honored method for articulating spiritual or religious experience in birth.

Hospital-based birth attendants tell stories about childbirth as well. In fact, although it may seem counterintuitive, physicians, nurses, and midwives who work in hospitals are just as reliant on narrative as home-birth midwives. But unlike home-birth

midwives, whose education and practice emphasize first-person birth stories, the genres available to hospital-based birth are clinical forms like obstetrics case history, and the patient chart. While narrative permeates obstetric practice, the stories that obstetrics providers tell are rarely acknowledged as such, and religious and spiritual narratives of hospital birth are relatively rare. Writing in a narrative genre like the obstetrics case history necessitates a set of conventions that emphasize physical aspects of pregnancy and birth while intentionally limiting more subjective aspects that are critical to describing spiritual experience.

Narratives of religious or spiritual experience in childbirth rely heavily on content that is highly subjective, affective, and symbolic—in some cases even transcendent or supernatural. Consider this birth story from Barbara Stanford, a nurse-midwife who is part of a group practice that emphasizes holistic, woman-centered care. I asked Stanford to describe a birth that had particular spiritual or religious significance. She described:

> *I had one couple that arrived to the hospital: it was a home birth couple that thought they were in labor, met with their home birth midwife, and there were no heart tones so they came to the hospital. It was a full-term intrauterine demise. And the baby was born. It was a very sad, poignant, horrible, wonderful birth. Perfect baby, cord entanglement of some sort. And I remember they had met; they were both park rangers. This would've been in the early nineties. They were both park rangers. They had a lot of connection with the sun and the moon and the earth, the trees. And when the baby was born he [the father] took the baby outside because he just wanted the spirits to meet—he had a Native American Indian background—and he wanted them to meet the baby. And [he] brought the baby back into the family. They had an older child and we bathed the baby together and dressed the baby together. . . I remember it being so beautiful and horrible . . . it was very sacred in the same way as a live birth would have been.*
>
> *About two years later I was working nights and she [the mother] had had a baby at home, and she was about six hours after her delivery and she brought the baby in [to the hospital] finally to show me the new baby. And I don't know how she. . . it was obviously important to her [just] like it was important to me that she came. I had no contact with her in the interim. But I remember that as feeling like a very*

> *spiritual event. That's probably one of the highlights [of my practice]. And I remember being . . . just emotionally it was so full of everything.*[8]

Stanford's story certainly includes clinical elements: she uses the term, "intrauterine demise" to describe the stillbirth, relates the results of a diagnostic test ("there were no heart tones") and, in a classic trait of narratives told by health care providers, provides us with a diagnosis, "cord entanglement." Still, although the clinical elements of the story are apparent, they are not its central focus. The story is not a case report: its primary goal is not to describe the biological events of the case for accurate communication and diagnosis. Instead, Stanford hopes to describe her experience of a birth (two births actually) as a spiritual experience. This story belongs in an entirely different genre, "the clinical tale." A clinical tale is amalgamations of two genres, one clinical and one literary. These stories, Sachs explains, "are clinical insofar as they have a factual, clinical basis . . . and they are 'tales' insofar as they have a subject—and a theme."[9]

Unlike the standard obstetrics genres, the clinical tale has a flexibility that allows a range of affective and symbolic descriptors. Take Stanford's narrative as an example. The emotional range of her story is huge, even contradictory: Stanford describes the birth as "sad, poignant, horrible, wonderful." The importance of symbols and metaphors is apparent: the couple were both park rangers who "had a lot of connection with the sun and the moon and the earth, the trees." Stanford feels free to reference non-physical aspects of the birth, describing how the father "took the baby outside because he wanted . . . the spirits meet the baby." She uses religious language, and she does not shy away from contradictions, saying, "I remember it being so beautiful and horrible . . . it was very sacred in the same way as a live birth would have been." The language is mostly

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[8] Barbara Stanford [pseudo.], interview by author, audio recording, 25 July 2010.
[9] Sachs, "Clinical Tales," 16.

non-technical; the descriptions are drawn from experience; the temporal frame spans two full years; the character descriptions are vibrant; and Stanford's syntactical construction favors an active voice. Finally, in contrast to a case report, which must be extremely precise, Stanford is able to use very non-specific language when elements of her narrative are difficult to articulate. This is an essential feature in a religious or spiritual narrative because of the difficulty of articulating spiritual experience. Notice how Stanford's sentences sometimes trail off when an event is difficult to describe and how she ends her narrative with the enigmatic but evocative statement, "emotionally it was so full of everything."

In contrast to clinical tales, obstetrics genres demand rigid order and perfect articulation, downplaying the affective and intentionally eschewing subjective content. Although this allows a great deal of precision and efficiency in medical communication, diagnosis, and treatment, it also makes these narratives ill-suited to describe spiritual or religious aspects of birth. Contrast Stanford's narrative with the following obstetrics case report describing an intrauterine demise:

> A 27-year old gravida 5, para 3, abortus 1, black female presented at 36 weeks estimated gestational age (EGA) with complaints of labor pains. Her antepartum course was remarkable for essential hypertension controlled with Labetalol. Ultrasound examinations at 20 weeks and 31 weeks had shown normal amniotic fluid and no fetal abnormalities. Two weeks prior to admission she had a normal fetal heart rate of 160 and slightly elevated blood pressure of 130/96. She stated that she had not been taking her blood pressure medications. There was no protein in her urine and no edema. On admission, she was having active contractions. Her blood pressure was 138/100. The cervix was 4 cm dilated. A fetal heart rate was recorded as 90. However, this was later determined to be a maternal heart rate and not a fetal heart rate. Due to the elevated blood pressure and suspected utero-placental insufficiency, the patient was taken to the OR for an emergency C-

> Section. A nonviable infant female was delivered, weighing 2,588 grams. Fetal autolysis was consistent with 72-120 hours of intrauterine death.[10]

This case report is very specific and highly detail-oriented. Compared to Stanford's narrative the language seems strikingly unemotional. Subjective elements are kept to a minimum and the author uses a highly technical lexicon. Note also how the author relies heavily on the passive voice: "A fetal heart rate was recorded as 90. However, this was later determined to be a maternal heart rate"; "A nonviable infant female was delivered." Use of the passive voice is typical in a case report. This practice has the emotional effect of limiting the presence of the physician, midwife, or medical student as a character. Her interior state is never revealed. It also impedes the reader's understanding of the patient's emotional or psychological state. Compare this with Stanford's rich character descriptions, both of her patient and the patient's family, and of her own internal state.

The pervasiveness of genres like the case report in obstetrics and the restrictions they place on providers helps explain the lack of attention to spirituality and religion that often seems to accompany hospital birth. Attention to birth as a religiously or spiritually significant event is so closely associated with home birth that it is sometimes assumed to be impossible to have a hospital birth in which spirituality or religion plays a major role. On several occasions in my interview process, women in the home-birth community asked me questions like, "Is there any spirituality in hospital birth?" One home-birth doula, Lisa Breton, even suggested sardonically that I should change the title of my dissertation to read, "Lack of Spirituality in Hospital Birth."[11] With the rigidity of obstetric narrative genres in mind, it becomes easier to understand the all-too-common

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[10] Robert Reese, American College of Osteopathic Family Physicians, "ACOFP – Strangulation of the Umbilical Cord by Amniotic Bands: A Case Report," Accessed September, 2010. http://www.acofp.org/resources/publications/archives/0108/0108_2.html.

[11] Lisa Breton [pseudo.], conversation with author, 17 February 2010.

assumption from both academic and lay home-birth advocates that obstetricians are blunted to the importance of spirituality, religion, and emotion in childbirth. Because they are restricted to rigid narrative forms, descriptions of the interior experience of birth, its emotional and spiritual affects on providers are rare.

In some ways the hospital culture and its attendant narrative genres do impede providers' ability to recognize childbirth as a spiritual or religious experience. However, this may be more of a stereotype perpetuated by a problem of available genres than a phenomenological issue. That is to say, it is not that providers do not *experience* birth as spiritually significant; rather, they cannot always *articulate* that significance within the accepted genres. When providers are given forums in which telling a different kind of story is possible, accepted, and even encouraged, I find that they are often keenly aware of the emotion, spiritual, and religious dimensions of maternity care. Take the narrative Stanford told me about the stillbirth she witnessed: far from being unaware of the religious and spiritual implications, she recognized them overtly. However, in the context of obstetrics genres, articulating those elements of the story would be difficult if not impossible, as we saw in the case report above.

Despite the important influences of obstetrics genres, their conventions do not completely define births for providers. As my interviews evinced, health care providers equipped with inadequate narrative forms can also invent new forms to narrate experiences they find spiritually or religiously meaningful. As stories like Nieman's and Stanford's show, the experience of birth is often profoundly spiritual for providers. Not content to allow the restrictive forms of traditional obstetrics to dictate the meaning of childbirth, the providers I interviewed embraced an alternative genre, "the clinical tale," to allow the narrative flexibility needed to articulate birth as spiritually or religiously significant.

In stark contrast to the stereotype that characterizes obstetrics providers as emotionally blunted and spiritually closed off, the providers I interviewed demonstrated an awareness of the spiritual and religious aspects of maternity care when encouraged to tell stories that facilitated articulation of those aspects. Chicago obstetrician Kevin Feldman put it lightly: "If it's not at least giving you goose bumps, you're just not going to do it."[12] In fact, the providers I interviewed often felt drawn to obstetrics by the affective and spiritual qualities of birth: Feldman's partner, doula Rachel Marini, called this "getting the birth bug," and several physicians, family doctor Patricia Woods for example, described a spiritual or religious calling to become a doctor.[13] Far from exhibiting the blunted affect several existing sociological studies of obstetricians report, many of my interviewees were moved to tears talking about the spiritual aspects of their practice—particularly so when they related personal narratives about individual patients. But it was only in a process like a narrative interview, when they were freed from some of the more confining conventions of the obstetrics genres, that providers could narrate important aspects of care.

These stories, filled with emotion and transcendence, represent an aspect of care that gets little attention in the vast literature surrounding hospital birth. Diverging radically from the conventions of typical obstetrics genres, the "clinical tales" that providers told drew on religious, spiritual, natural, and mythological traditions generally considered outside the scope of medical practice, and often outside the providers' own self-identified religious framework. As alternatives to the traditional case history, these

[12] Kevin Feldman [pseudo.], interview by author, audio recording, 14 February 2010.
[13] Rachel Marini [pseudo.], interview by author, audio recording; 17 February 2010, and Patricia Woods [pseudo.], interview by author, audio recording, 25 March 2010.

stories allow for the expression of both spiritual and clinical aspects of hospital childbirth.

FORMAL MEDICAL NARRATIVES

> *The order of the entire 'history' is more or less inviolable.*
>
> –Kathryn Montgomery Hunter, *Doctor's Stories,* 1991

> *Although it is not a literary enterprise, the practice of medicine advances its work through textual, or language- based, means and therefore may, like literature, know more than it can tell. The texts of medicine—for example, the medical interview, the case presentation, the hospital chart, and the consultant's report—can also be found to reveal more than the sum of the meanings of the individual words.*[14]
>
> -Rita Charon, *Narrative Medicine,* 2006

Acknowledgement and analysis of the importance of narrative to medical practice, or, as Literature and Medicine scholar Anne Hudson Jones puts it, "understanding . . . how stories are told and why it matters," is critical to understanding the lack of discourse about spiritual and religious aspects of hospital birth.[15] This section will look at formal medical narratives from several obstetrics genres, showing both their usefulness to patients and providers and their inadequacy for addressing spiritual and religious aspects of patient care. This section focuses primarily on cases of patient death, since providers consistently mentioned these births as spiritually or religiously significant.

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[14] Rita Charon, *Narrative Medicine: Honoring the Stories of Illness* (Oxford, UK: Oxford University Press, 2006), 24.
[15] A. Hudson Jones, "Narrative Based Medicine: Narrative in Medical Ethics," *British Medical Journal* 318, no. 7178 (January 23, 1999): 253.

The basic obstetric genres, case presentations, case reports, and the patient chart, are narrative forms that lend themselves well to examination using the analytic tools of the humanities. In fact, one of the major ways in which the medical humanities have contributed to humanizing developments in medical education and practice has been through examining stories. The fields of Narrative Medicine and Literature and Medicine explicitly focus on narrative, and disciplines like medical anthropology, medical sociology, and the history of medicine likewise acknowledge its importance in the construction of medical knowledge and practice.

The idea that medicine is essentially a narrative practice will come as no surprise to humanists working in these fields, but for clinicians and patients familiar with medicine's claim to objectivity, the idea warrants some explanation. In her insightful account of the stories physicians tell in medical practice, Hunter points to what she calls "the narrative structure of medical knowledge."[16] Hunter's book contests the idea that medicine is a purely scientific practice, choosing instead to examine the narratives that define medical knowledge and determine the norms of medical practice.[17]

The stories we tell are powerful. Narratives, as ways of shaping chaotic experience into meaningful coherence, are not simply passive reports of a series of events; they are ways of knowing that help define culture and influence action. When providers are encouraged to tell stories only within the confines of a certain genre, they will naturally begin to privilege the events that take priority in those specific stories. Sociologist David Yamane points out in his proposal for a narrative-based approach to

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[16] Hunter, *Doctors' Stories: The Narrative Structure of Medical Knowledge*, 55.

[17] For now I am leaving aside the question of whether pure science is also narratively structured and constituted. Many prominent voices, particularly in the philosophy and history of science have argued compellingly that narrative and symbolism play vital roles in the construction of scientific theories, the adoption of certain theories over others, and even in the day–to-day practice of experimental science.

studying religious experience that culturally available narrative forms not only shape peoples' interpretations of a series of events, but also play a part in determining which events will take place.[18] In obstetrics, this means that limitations in the narrative genres providers must tell also influence how they will act.

The act of recording events, developing and narrating stories comprises a great deal of the work that medical professionals must perform. The constructs of these narratives inevitably influence patient care. This happens metaphorically, as we have seen in the case above: narrating a birth within the conventions of the case history will most likely foreclose the possibility for its spiritual or religious interpretations.

Narrative restrictions can also have very concrete effects on patient care. Take the example of another obstetrics genre with very inflexible constructs and conventions: the patient chart. The constructs that determine when and how events must be recorded in the chart influence when and how those events will take place. For example, obstetrics nurse Lilly Kelly explained how a transition to computer charting forced her to take babies away from their mothers prematurely:

> *Computer charting hasn't helped that a lot because when the baby's born, they won't put that baby in the system until they get the weight on that baby. So you have to take that baby off at some point to do a weight on it or the secretary won't admit it and then all your vital signs and everything you're doing—you can't chart it at the bed. If I have a very stable baby who's laying on her mom and totally content, I have to take her at some point to get a weight. Because if I don't get this silly weight over then she doesn't get admitted and then you can't do any of your charting and then you can't get her off the floor so you can't take the next patient. You have a beautiful healthy big baby and it's like, do you really care right now if she's seven pounds or eight pounds? I don't. I mean at some point the parents are going to say, "Oh, what's her weight?" Oh, fine, can I take her off, get her weight, and I'll give her right back to you. But that rush is to go and get*

[18] David Yamane, "Narrative and Religious Experience," *Sociology of Religion* 61, no. 2 (Summer 2000): 171-189.

> *her admitted. Because the ID bands take a bit to print, and they won't do any of it until they have the time of birth, the weight on the baby. So it's like a vicious little circle. If I told you the date and time of birth why can't you just admit this baby and give me an account? Because that nurse is opening up that thing and she's putting in the weight and the time of birth and everything when she charts. So I don't understand why the needed to admit the baby because it would certainly want to be with mom for a lot longer.*[19]

Kelley's story represents one of the pitfalls of failing to understand the patient chart as a narrative requiring some flexibility. Rather than allowing a nurse to record the story of the birth as it happens, the inflexible charting system forced her to perform events in a predetermined order that conforms to the construct of the genre. The designers of the computer system most likely viewed the baby's weight as a numerical fact, rather than a record of an event, weighing of the baby. Because it did not allow for temporal flexibility, the rigid nature of the new computer chart forced Kelley to weigh the baby prematurely, interrupting the moment of bonding that happens after a healthy normal birth. The inflexible narrative demands of the charting system forced her to act differently than she would have had she been allowed to narrate events in the order they occurred naturally in the story. This is just one way in which the pre-determined constructs of a narrative form actually controls and determines events rather than merely recording them.

A wide range of people from both inside and outside the medical establishment are invested in the idea of medical practice as a pure or applied science. This means that there is some resistance to the idea that medicine is rife with stories. What engenders even more discomfort is that, far from being simply emotional afterthoughts to the scientific work of medicine, these stories are vital components of the practice of medicine itself. Though medical practice is based in theoretical and empirical knowledge, it is through narrative forms that the real work of medicine actually takes place. The stories

[19] Lilly Kelly [pseudo.], interview by author, audio recording, 14 February 2010.

that physicians tell allow them to take abstract knowledge based on the amalgamation of thousands of patients and make it useful in the contingent and concrete case of a specific patient. "Medical stories," Hunter writes, "are a well established way of sorting through and tackling problems of diagnosis and treatment," and without them medical practice would be impossible.[20]

The "case," a clinical, descriptive narrative construction of an individual patient, is the fundamental narrative unit of medical practice. Sachs describes the process of narrative transformation by which a patient comes to a physician as "a sufferer" and is transformed into "a case":

> The patient presents himself *as* a patient, a sufferer, in the expectation (the hope, the dread) that the physician, an expert, will detect characteristic features, perceive him as a *"case,"* for it is only when a "case" has been delineated that an appropriate "treatment" can be suggested. Thus the *first* act of medicine is to listen to a personal story, [and] extract or abstract from it a . . . "case."[21]

Obstetrics, like all medical practice, relies heavily on the process of narrative transformation that Sachs describes to appropriately diagnose and treat pathology, and, in the case of normal labor, to respond appropriately to any emergent problems. As Hunter describes, "The case is the basic unit of thought and discourse, for clinical knowledge, however scientific it may be, is narratively organized and communicated."[22]

Hunter calls the case presentation a "doubled narrative" because, as she sees it, the case attempts to recount both the physician's and the patient's story in one narrative. Hunter is careful to emphasize that the case presentation is "not the patient's story, although it depends upon and in part reconstructs it."[23] As Sachs suggests, the transition

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[20] Hunter, *Doctors' Stories: The Narrative Structure of Medical Knowledge*, 5.
[21] Sachs, "Clinical Tales," 16-17.
[22] Hunter, *Doctors' Stories: The Narrative Structure of Medical Knowledge*, 51.
[23] Ibid., 53.

from a personal story of a patient's illness experience to a formal case is a process of both extraction, pulling out the elements of the story that the physician sees as relevant to the case, and abstraction, the transformation of a unique, individual patient experience into a single example of a recurring type: cord entanglement, shoulder dystocia, or fetal demise. This process of extraction and abstraction is magnified in obstetrics narratives where for the vast majority of cases the diagnosis will simply be "active labor." Many scholars have pointed out that this process, though necessary to the work of diagnosis and treatment, is also highly reductive. It contributes to the lack of respect for individuality of patients that is a common complaint in Western medicine.

Internist and literature scholar Rita Charon traces this phenomenon to eighteenth- and nineteenth-century developments in pathology and germ theory, writing, "Disease began to be seen as separable from the patient's body. Instead of singular occurrences in individual human lives, diseases were understood to be repetitive phenomena no matter who was the host."[24] Nicholas Jewson describes this transformation as the "disappearance of the sick man from medical cosmology."[25] Jewson suggests that successive advances in medical technology have led to progressively decreased focus on individual patients, to the point where the patient herself becomes almost vanishingly insignificant. Meanwhile, increasing emphasis is placed on the results of various diagnostic tests performed by machines. Michel Foucault similarly describes a transition from humoral theoretical medicine to empirically based medicine, during which the patient was transformed from an individual subject to an object by the objectifying clinical gaze of the physician. In

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[24] Rita Charon, "Literature and Medicine: Origins and Destinies," *Academic Medicine* 75, no. 1 (January 2000): 23.

[25] Nicholas Jewson, "The Disappearance of the Sick-Man from Medical Cosmology, 1770-1870," *Sociology* 10, no. 2 (May 1, 1976): 225 -244.

these theoretical accounts, the physician is typically seen as the wielder of a great authoritative power that she gains at the expense of a disempowered and objectified patient. And while this critique has been helpful in terms of motivating various patients' rights movements, it is also limited in that it neglects on one hand a complicit desire for the benefits of diagnosis and treatment on the part of patients, and on the other the importance of individualized, spiritually significant patient-physician interaction on the part of physicians. The narration of the events of an illness or a birth as a case is a process that may benefit patients and even impede physicians, in addition to the reciprocal effects often described in humanities and social sciences literature.

The events or experiences a health care worker will include in a case report will typically not be emotional or spiritual since emphasis is placed on the objective elements of the specific case. This emphasis on material elements of clinical pathology is not a reflection of carelessness on the part of the physician; on the contrary, it reflects a goal of allopathic diagnosis and treatment that is shared by patient and physician. Recall Sacks' description, "The patient presents himself *as* a patient . . . in the expectation that the physician, an expert, will detect characteristic features, perceive him as a 'case,' for it is only when a 'case' has been delineated . . . that an appropriate 'treatment' can be suggested."[26] I want to emphasize again that the case report is *not* simply a retelling of the physician's version of a story lived by the patient. Instead, it is a narrative form intended to eschew subjective content towards a very specific end goal. As both Neiman and Stanford's stories show, the removal of subjective elements not only entails removing emotional and spiritually significant details that are important to patients, it also means removing a great deal of content that might be vitally important to the

[26] Sacks, "Clinical Tales," 16-17.

provider's understanding of the event as it took place. Hunter explains, "The aim of medical discourse is always to eliminate or control the purely personal and subjective, *whether its source be patient or physician*, so that the physical anomalies that characterized illness can receive the attention their successful treatment requires."[27] The intent is to make an individual narrative into a single example of a recurring type, making diagnosis and treatment possible. The rigid conventions of the case also facilitate vitally important communication between the myriad of professionals involved in the medical care of the patient. Given the number of medical professionals involved in the care of an average obstetrics patient, this element of the case presentation is critical. As Hunter points out, the strict narrative conventions of the genre allow professionals to communicate to "others who know the medical language well, but this particular patient not at all."[28]

Despite the litany of benefits that obstetrics genres provide in terms of ordered diagnosis and treatment, they fall short in addressing the spiritual aspects of childbirth for *both* providers and patients. The inadequacy of these genres is heightened in cases of maternal or infant death, where spiritual and religious aspects of birth are magnified. Hunter says of traditional medical narrative forms, "The goal of the case presentation is a precise, scientifically accurate account of the patient's condition, and thus it is not surprising that its language is plain and unmetaphoric." Given this goal, it is reasonable to expect the case to elide subjective and emotional content. However, in some birth stories—for example, a narrative concerning infant or maternal death—a precise and accurate account of the patient's condition cannot be easily achieved without resorting to

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[27] Hunter, *Doctors' Stories: The Narrative Structure of Medical Knowledge*, 52.
[28] Ibid.

emotional and subjective language. In stories like these, where emotional, psychological, and spiritual elements would naturally predominate, the case report, like the hospital culture it informs, often seems callously inadequate.

Take, for example, the following case report. The report describes the stillbirth of a baby with a rare congenital anomaly known as cyclopia, in which the baby is born with, among other defects, only one eye. The affective and dramatic content highlights the gross inadequacy of the case report to describe emotional or spiritual content. The report reads:

> A 30-year-old Indian woman of Asian origin, sixth gravida, was referred to the labor room of our hospital.
>
> There were no ultrasound examinations performed during this pregnancy as our patient had not received regular antenatal care. We found out that the head of her baby was already outside the vulva but the remaining parts of the baby were not yet delivered. Further examination was carried out and a diagnosis of shoulder dystocia with intrauterine fetal demise was made.[29] A stillborn baby boy of 3.5 kg was delivered using McRoberts' maneuver.[30] The baby was suspected of having features of cyclopia and this was later confirmed by autopsy and anatomic correlation. The mother had a cervical tear which extended into the lower segment of her uterus, thus leading to the rupture of her uterus.[31] There was a massive broad ligament hematoma on the left side of her uterus. A total abdominal hysterectomy was carried out.

This narrative graphically describes a terrible series of events. The form of the narrative is highly descriptive of objective facts, but so lacking in emotional description that a lay

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[29] Shoulder dystocia is the technical term for the event described in the previous sentence: the baby's shoulders are too large to fit through the pelvic outlet, so the head delivers while the rest of the body remains inside the uterus. Intrauterine fetal demise, often abbreviated IUFD, is the term used to describe what used to be termed stillbirth, a death that occurs inside the uterus.

[30] A technique where the mother pulls her legs closely to her chest to widen the pelvic outlet and make delivery of the shoulders more likely.

[31] Uterine rupture is a rapid, catastrophic event in birth where the uterus tears open and the baby is expelled into the woman's abdominal cavity. If it is not immediately treated with cesarean section delivery, it almost inevitably results in the death of the baby and eventually the mother as well. In this case it suggests that the woman has been laboring without access to medical care for some time.

reader might not even fully understand the grave details of the story on first reading. A woman comes to the hospital labor room in labor. Her child, a baby with cyclopia is only half delivered, his head is protruding from her vagina, but his shoulders will not deliver. The obstructed labor has caused a tear in her uterus that necessitates a hysterectomy.

A medical professional familiar with the terminology and form of this type of narrative will immediately recognize the case as a tragedy. The complete lack of prenatal care, the description of minority status, and the patient's high number of pregnancies (five) at a fairly young age, all combine to inform a reader familiar with this genre that this woman is perhaps on the margins of society, and that she likely had grossly inadequate access to medical care. The "total abdominal hysterectomy" means the loss of this woman's fertility—although she is only thirty, she will never become pregnant or give birth again. The uterine rupture suggests that she has been laboring for some time without medical care, the pressure of contractions against the baby's body eventually caused the cervix to tear and rupture her uterus—and she has likely suffered all of this unnecessarily because of her social status. The content of the narrative, and the implications obvious to someone trained to read this narrative form are provocative, emotional, and disturbing, but the conventions of the genre minimize those elements to a distressing extent.

Sociologist Renee Anspach has examined the language of case presentations on an obstetrics and gynecology service. Suggesting that the case presentation has a ritual function by which "physicians learn and enact fundamental beliefs and values of the medical world," Anspach identifies four features of the case report that represent the

values of the medical establishment.[32] First, they separate biological processes from the person who is undergoing them. Anspach refers to this as "depersonalization." Second, they rely on the passive voice, what she calls "omission of the agent." Third, they posit technology as an actor. Finally, they rely on "account markers," phrases like "the patient reports," "the patient states," and "the patient denies" that call into question the legitimacy of the patient's subjective experience. Read with Anspach's analysis in mind, this case report is actually slightly more humanizing than the typical case report, since it breaks with some of the features Anspach describes in several ways. For example, the phrase, "We found out that the head of her baby was already outside her vulva but the remaining parts of the baby were not yet delivered," uses the active voice as well as the term "baby," slightly mitigating the depersonalization and omission of the agent common in other similar reports. Compare the following excerpts from other case reports of babies born with cyclopia: one 2008 case report reads, "A live female *infant* (1.5kg) [was] delivered by cesarean section."[33] A 2003 case report reads similarly, "An aborted female *fetus* of 16 weeks gestation was examined,"[34] and an earlier case report from 1983 uses the archaic term *monster,* reading, "On 13 August 1982 a *female cyclopean monster* was born spontaneously with cephalic (vertex) presentation."[35] The use of the term *baby* rather than "infant," "fetus," or even "monster," personalizes the narrative somewhat. The same is true of the phrase, "a stillborn baby boy," which is a humanizing description involving three lay terms *stillborn, baby,* and *boy*. More common in such a description

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[32] Renee R. Anspach, "Notes on the Sociology of Medical Discourse: The Language of Case Presentation," *Journal of Health and Social Behavior* 29, no. 4 (December 1, 1988): 357.

[33] ," Otuaga, "ISPUB - Cyclops Deformity In Benin City, Nigeria: A Case Report," http://www.ispub.com/ostia/index.php?xmlFilePath=journals/ijn/vol10n1/cyclops.xml.

[34] Shankar (Mahadevan)

[35] "H. J. Garzozi and S. Barkay, "A Case of True Cyclopia.," *The British Journal of Ophthalmology* 69, no. 4 (April 1985): 307-311.

would be the depersonalizing terms *male*, *infant*, or *fetus*; and, instead of stillborn, *fetal demise* or *incompatible with life*. Still, despite its small breaks with the conventions of the obstetrics case report, the narrative ultimately fails to describe the existential, emotional, and spiritually charged elements of the events it describes, nor does it address the psychological and emotional needs of the patient.

Stories of delivering a baby who is dying or dead came up in nearly every interview I conducted with a maternity care provider. Providers described patient death as one of the most difficult aspects of obstetric practice, and as an emotional and spiritual event that birth attendants must process as such. As Woods suggested in our interview, physicians and nurses are unique in Western society in that they are routinely forced to confront death and suffering. Consequently, the depersonalization typified by the case report is often touted as a necessary protective measure against the emotional distress a physician is likely to experience from repeated exposure to death. By contrast, Woods describes the desire to medicalize death negatively and views it as a major barrier to acknowledging birth as a spiritual event:

> *As physicians we can't push it [death] away all the way, but we can medicalize it. We can make algorithms and protocols and all sorts of things. We can pretend that we have knowledge, and we have words, and we know what to do . . . but the truth of the matter is we don't have control. And I think we like the illusion of control.*

Narratives like the obstetrics case report allow a certain emotional detachment from the repeated emotionally traumatic nature of confronting death and suffering. This is particularly important in cases of infant death, where existential aversion is common. Woods said of the repeated exposure to death and suffering a physician can expect to have over the course of her career:

> *I think a lot of people are afraid they don't have the emotional reserves to deal with that kind of intense pain repeatedly in their careers, and so they just back*

> *away from it rather than experiencing it and then dealing with it appropriately. I think people become more cynical, and kind of hard hearted a little bit, trying to protect themselves.*

All physicians and nurses can be expected to face illness and death repeatedly in their careers. But providers in obstetrics, and, to a slightly lesser degree, midwifery, can expect repeated exposure to the death and suffering of infants, an event so fraught with existential implications that Samuel Beckett used it as a theme in his bleak absurdist drama *Waiting for Godot*.[36] The constant threat of infant death takes an emotional toll on providers that they must confront at some point in their careers. Obstetricians are in a unique situation, in that they must face a difficult reality that most people will never experience first-hand: birth is often associated with death. As physicians responsible for the care of those patients, the emotional insult can be even greater. Army obstetrician Austin Franklin said:

> *There are times when it doesn't matter what you do as a doctor, there are bad things that are going to happen to good people. And it's just the nature of life. And most lay people don't see that day in and day out because your exposure to your friends or family that may deliver babies is going to be limited to a couple dozen over a long lifespan of people that you know personally—well enough to know the sex of their baby, how big it was. Whereas for what we do, we're going to potentially manage a dozen patients in labor per day. And so you, in essence, are having a lifetime of exposure to babies in one day, multiply that times every day—every day of your career. And so obviously when two percent of babies are going to have a genetic problem or ten percent of women are going to have problems with preeclampsia or high blood pressure in pregnancy, you're going to see a lot of that; whereas you as a person, exposure to a family or friend that has baby affected by Down's syndrome or they had to deliver prematurely because they had twins or triplets or whatever, is very limited.*[37]

Traditional obstetric narratives may seem an appealing means for approaching the topic of infant death because they minimize the affective and spiritual elements of such an

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[36] See Chapter 7 for an extended discussion.

[37] Austin Franklin [pseudo.], interview by author, audio recording, 25 May 2010.

event, thereby narrating the event in a way that seems emotionally tolerable. And given the repeated emotional insults that an obstetrician can expect over the course of a career, some degree of emotional blunting seems appealing. However, the emotional and existential trauma that attends such an event is not removed by what Woods calls, "medicalizing" the narrative. Instead, as Woods suggested, it can lead to providers becoming "cynical, and kind of hard hearted" precisely at the moment when emotional maturity and spiritual growth might be most critical.

Furthermore, acknowledging the emotional and spiritual elements of medical care can also be sustaining for providers. Woods said:

> *I would be out of here in a heartbeat [if I didn't empathize with my patients]. I tell people this all the time: If I don't have tears with my patients and I don't laugh with my patients, I am going to be a landscaper or go work at Wal-Mart or go do something else, because it's too hard. This job is way too hard to do it without that for me. That's where my juice comes from for me. It is sustaining. In the same way that this morning I looked at the little leaves on my rose plants that I planted last week and they have new little leaves coming out, and it's amazing. This little plant that was almost dead . . . [has] got little leaves coming out. If you can look at people that way it's the same thing. It's very sustaining. It's acknowledging that interconnectedness or that greater being . . . that's part of all of us. And honoring that. I couldn't do this job without that, I honestly couldn't because it is just way too hard. It's certainly not the money.*

Although opening oneself up emotionally to patients in times of trauma can be necessary and even sustaining, the narrative genres available to obstetricians reflect a culture that often does not allow providers to address the emotional and spiritual aspects of patient death. This is particularly true for initiates, who are discouraged from displacing emotional responses to patient death both in their actions and their patient narratives. Obstetrician Beverly Mason, for example, talked about being discouraged from crying about a patient whose baby died during a delivery she witnessed as a student:

> *You had to see so many patients; you were working so hard; you were tired, so I can sort of understand being in that position. I had an attending who was fabulous. He was older, almost semi-retired already but just wonderful . . . And we had had a patient on the floor. And it was a different era. The baby was breech and she had ruptured her membranes and we were doing daily [rounds]. And [the baby was] preterm: twenty-seven, twenty-eight weeks. The survival rate wasn't as good then, but you'd watch and the [fetal heart rate] strip was getting worse every day and I'd be saying, "Why don't we go ahead and section her? Why don't we go ahead and deliver her? Why don't we go ahead?" And sure enough, she prolapsed her cord on the floor and the baby died. But the baby weighed eleven hundred grams.*[38] *Even in that time we could have saved it. And I was crying, crying. I was already attending [deliveries] and I was a first year or second year . . . I didn't have a lot of power so I'm sure I wasn't a third or a fourth. But the attending, this guy, Sam James, he was wonderful, said, "You can't do that. We have to move on. You can't feel sad for [her]" . . . . I was just horrified that I couldn't mourn for this person or even be frustrated that people wouldn't listen to me when I kept saying, "Why don't we deliver her? Why don't we deliver her now? Why don't we go ahead? This baby's not doing so well."*[39]

Rather than benefiting from the emotional distance her attending suggested, Mason "was just horrified that I couldn't mourn for this person." Notice how Mason does not demonize her instructor even though she experienced the event as traumatic. Instead, she describes him as "fabulous . . . just wonderful." For Mason, the emotional distance from death enforced by medical culture does not imply a problem with a specific provider.

Woods also described the emotional repercussions of the medical imperative to gain psychological distance from infant death. She described her experience with the death of a very premature baby as a medical student:

> *Another birth that I attended when I was a student that struck me and has made the way I approach things different is [this one]. I was working with a pediatrician at mainland and he was called to the hospital because there was an emergency C-section. And they delivered a horribly premature baby—sixteen, eighteen weeks. And they'd started the resuscitation and then they looked and said, "this is just not going to matter," so they stopped the resuscitation. And*

[38] About 2lbs, 6oz. A baby with this weight will generally survive in a neonatal intensive care unit.
[39] Beverly Mason [pseudo.], interview by author, audio recording, 30 September 2010.

everybody, everybody walked away and left that baby on the resuscitation stand to die by itself. And I put on gloves and held that baby until it died, and went back to clinic late. I had a few repercussions. But when I told the faculty what I was doing I think he stopped and thought, "I just left that baby." I mean everybody just decided the baby was going to die anyway. They didn't take the baby to the mom; I mean they just walked away. And I was horrified. I was a third year medical student and I was absolutely . . . I mean the baby wasn't bigger than a pound of hamburger, but it was a baby.

I think sometimes as physicians or as educators we either are good examples or horrible examples, and we learn from both of those when we're students, and that was one of those horrible examples that struck me. That has made me approach death and dying differently, very differently, because it was so horrifying to me.

MPW: Why do you think they did that?

PW: Now I think I understand much better. I think it is [this]: if you hold that baby and you open yourself up to that, it's very painful.

Both Woods and Mason describe negative rather than positive emotional consequences to the common clinical attitude that divorces death from its emotional and spiritual relevance. Ironically, this attitude is often described as an attempt to emotionally protect providers.

Given the importance of integrating traumatic experiences into a comprehensible emotional framework, and the inadequacy of ignoring or marginalizing their emotional impact, providers must resort to alternative narrative genres like the clinical tale to articulate experiences they perceive as spiritually or emotionally significant.

"Clinical Tales" of Birth

Oliver Sachs coined the term "clinical tales" in a 1986 article for the journal *Literature and Medicine*. As the subtitle for his newest book—a series of descriptive patient narratives—"clinical tales" described a type of narrative that twinned the medical

case history with vivid descriptions of the lives of individual patients.[40] Coyly claiming to have "no 'literary' aspirations whatever," Sachs remained willfully non-committal on the question of whether the clinical tale constituted a new literary genre.[41] Rather he suggested that the form came out of necessity because the content of the medical encounters he experienced could not be articulated in the traditional medical history. Sachs wrote, "If I write 'Clinical Tales' it is because I am *forced* to; because they do not seem to me a gratuitous or arbitrary compound of two forms, but an elemental form which is indispensible for medical understanding, practice, and communication."[42] Sachs' emphatic statement "I am *forced* to" underscores his insistence that the traditional narrative forms available to physicians are often wholly inadequate to describe clinical events. Traditional medical narrative forms like case reports and medical histories were developed as tools to generalize a single, messy report of illness into a member of a universalizable diagnostic category. Although this makes them uniquely well suited for organizing and structuring allopathic medical knowledge, the unintentional result is that these forms have inherent reductive tendencies. In addition to downplaying or eliminating narrative elements that describe the psychological, emotional, or spiritual effects of an event on the patient, these genres also limit the provider's ability to articulate the personal significance of clinical events in their own lives.

Compare the earlier case report about cyclopia to Karina Nieman's description of the emotion involved for a provider in delivering a baby with a lethal congenital anomaly. She said:

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[40] Sachs, "Clinical Tales."
[41] Ibid., 16.
[42] Ibid.

> *I'm supposedly an atheist, but I'm all like, "Universe, I need this." Natalie Phillips*[43]*, there's a HIPPA violation for you. Jacked baby, not a baby meant for this world, and also a pretty highly desired pregnancy. So I deliver this dead baby. Which fucking sucks. Delivering a dead baby blows. Everyone's crying, and . . . you deliver this baby and instead of delivering this baby that like cries you have this baby that's floppy in your arms, and nobody's in the room because nobody gives a shit. Not that they don't give a shit, but they just, nobody knows what to do, and you're trying to cut the cord by yourself. So I deliver this baby, and I have just come off a month of nights with two of my favorite other residents. . .finally I walked out, and I always get really teary, I always need a moment after the IUFD,*[44] *so I'm standing outside this door, you know you don't want to walk in the door, not that anyone is going to care but it's an alone moment. "Okay universe, for real, I need that delivery, I need the one where it is happy and good, and . . . I need* that *one.*

Nieman's narrative, like several other narratives I collected recounting deaths, ends with the resolution of the traumatic event in the form of a second birth. Nieman describes her prayer to the universe, "*I need that delivery, I need the one where it is happy and good, and . . . I need* that *one.*" The story resolves with the universe providing the live birth that she asks for:

> *Five AM a primip, no two, I had two admissions, young, first baby, healthy, nothing wrong, she [even] had her prenatal records, "Oh my God." Dad was there, Grandma was there, she delivers, she starts at five, goes to complete at seven o'clock, she delivers the baby at seven fifteen. Dad's like crying, Mom or Grandma is doing the praise Jesus thing, praying. I'm just like, "Thank you universe, this is what I needed." I needed, I asked, and literally the patient was like, "Thank you so much," saying to us, "Thank you," and I was like, "no no no no no! Thank you! Because I asked for you." And she didn't get it, and my nurse was like, "Yeah, she did, she asked for you." Because there was nobody on L and D except for the IUFD patient, nobody in triage, nobody in a single room, it was dead until they walked in and I was like, "I need somebody to walk in the door,"*

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[43] I have changed the patient's name for the purposes of this paper, but I want to note that the importance of medical privacy often adds to the depersonalizing aspect of case reports. The necessity to keep names secret, to refer instead to "the patient," often impedes the ability of providers to empathize with their patients. They occasionally told me these names in their stories as an attempt to personalize their narratives. Woods, for example, said at one point, "*Her first name is Stephanie, I don't think she'll mind that I shared that.* "

[44] Intrauterine fetal demise, a stillbirth.

and they did. "I need another delivery." That was my Rolling Stones story, because sometimes you don't always get what you want.

MPW: You get what you need.

N: Yeah, you get what you need. And I asked for that one, so that was my spirituality moment. It got to me.

The spiritual significance of Nieman's narrative, what she describes as "my spirituality moment," is in the linking together of two completely different births occurring at different times, something that would be impossible with the rigid temporal ordering of the traditional case history. Many of the stories providers told me included events far beyond what could be included in a case history, which necessarily ends when the patient leaves the hospital. By contrast, many of the birth stories I collected from providers related the spiritually significant births to events that occurred far in the future, thus integrating the story into a larger narrative of the spiritual life of a provider. Another advantage of alternative narratives that allow temporal ordering that goes far beyond discharge from the hospital is the possibility for spiritual resolution of a difficult birth.

Nieman's narrative stands in stark contrast to the case report presented earlier. Although it is not the same case, the form of the case presentation varies very little, so the case report Neiman delivered about this patient would have been very similar in terms of form and lack of emotional or spiritual content. While the earlier narrative begins typically, with, "A 30-year-old Indian woman of Asian origin, sixth gravida," Neiman begins her narrative with the phrase, "I'm supposedly an atheist," signifying that the story will be focused on spirituality, and that the primary character will be Nieman, rather than the patient. Her use of the present tense gives the story a sense of urgency and immediacy, and her consistent use of the active voice links her directly to the drama and tragedy of the delivery. Compare the phrase from the case report, "A stillborn baby of 3.5 kg was delivered using McRobert's maneuver," with Neiman's "So I deliver this dead

baby." Neiman's description leaves out the weight of the baby and does not discuss any technical aspects of the delivery. The active voice, the use of the term *dead* rather than *stillborn*, and the avoidance of technical terminology and numbers makes Neiman's story seem much less emotionally remote than the case report.

It must be addressed that Nieman's narrative, like the obstetrics case history I discussed earlier, leaves out the perspective of the mother whose baby has died. Although I recognize the vital importance of addressing the spiritual and religious needs of patients, I include Nieman's story as an important example of a clinical tale here because, despite its inattention to the patient as a character, it describes a stillbirth as a spiritual and emotional event in the life of a *provider*. I want to be clear that I recognize this specific narrative as one that does not address the inadequacies in attending to the emotional and spiritual needs of patients that the case history often engenders. However, the narrative remains an important example of a narrative genre that addresses the often-overlooked emotional and spiritual experiences of a provider—this one happens to be a resident in the midst of the grueling process of first-year obstetrics residency.

Much has been made of the idea that the case history represents a sort of narrative hijacking of the patient's own illness (or in our case birth) story by the physician. Arthur Frank, for example, eloquently describes the act of seeking medical care as "a narrative surrender" wherein the patient surrenders her ability to tell the story of her illness to the physician. Much less commonly discussed are the implications of a dominant narrative genre that intentionally limits the subjective, affective, or spiritual for providers. Just as the rigid form of the case history, with its preference for objective empirical facts, often prevent physicians from marking aspects of childbirth that are spiritually significant to the patient, the physician must also refrain from marking as significant aspects of the

birth, pregnancy, or family history that she finds emotionally, spiritually, or religiously significant to her own life.

The emotional needs of providers are often overlooked. As Austin Franklin pointed out, an obstetrician can expect to experience the amount of human tragedy in one day that many individuals will experience in a lifetime. Combined with the stigma surrounding mental illness among providers, this idealization of the stoic physician culminates in physician suicide rates that are twice that of the general population. In the Unites States, physician suicide results in deaths equivalent to more than an entire graduating class of medical students every year. The situation is particularly grim for students and residents in their early years of training, when harsh working conditions and little emotional support exacerbate the difficulty of repeated exposure to trauma and death. Recall Beverly Mason's empathy with the curt treatment of patients by obstetrics trainees: "*You had to see so many patients; you were working so hard; you were tired, so I can sort of understand being in that position.*" Between 15% and 30% of medical students and residents screen positive for symptoms of depression and, after accidents, suicide is the leading cause of death for medical students. A provider cannot adequately and empathetically address the emotional and spiritual needs of her patients until she can first mark the event as emotionally or spiritually significant in the first place, and the available narrative genres often do not allow for that.

Charon addresses the provider's perspective in her discussion of the narrative forms available to young physicians. She writes:

> If your patient dying of prostate cancer reminds you of your grandfather, who died of that disease last summer, and each time you go into the patient's room,

> you weep for you grandfather, you cannot write that in the hospital chart. We will not let you.[45]

Similarly, if an obstetrics resident feels, as Nieman did, emotionally devastated from attending the delivery of a stillborn baby, she cannot say in the case history, as she did to me,"[delivering a] dead baby . . . fucking sucks. Delivering a dead baby blows. Everyone's crying, and . . . you deliver this baby, and instead of delivering this baby that like cries, you have this baby that's floppy in your arms, and nobody's in the room because nobody gives a shit."

Given an expanded range of conventions, young providers can begin by telling stories that express their own emotional and spiritual reactions to their training.

I want to end this chapter with another narrative from family medicine physician Patricia Woods. This narrative shows the full potential of the clinical tale to express an event as spiritually significant in the life of a patient and a provider. The following narrative not only recounts the significance of a patient interaction in her own emotional and spiritual life, it also features the patient as the central focus of spiritual experience. The narrative is lengthy, and I include it in its entirety. Woods has a practice of keeping photos of memorable patients on the door of her office. She said, pointing to her office door:

> *His picture's up there, too. I was early in residency, and I think this was one of the first people that I took on as one of my patients, one of my continuity patients. She came in and she was twenty years old, not married, and was just the neatest Mom. Pregnant accidentally and a little flipped out with that, "Oh my god, I'm going to have a baby." And then she and her partner married, and they have since divorced. Then we sent her for an ultrasound, she was sized greater than dates and turned out she had twins, so then it was another flip out.*
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> *She worked so hard to quit smoking during the whole time. She was great. She wanted to do everything the right way, really struggled. When she was about*

[45] Charon, *Narrative Medicine*.

twenty-eight weeks, probably twenty-seven weeks, she got preeclamptic. She came into clinic one day and she was telling me, "Gosh I see all these spots," and her blood pressure was high, and her protein in her urine was up so we had to admit her. We didn't want to deliver the babies that early and so we admitted her and she was managed by OB because she's twins and preeclamptic and sick. But I went to see her every day, several times a day. And she made it about a week and her kidneys started to fail and she kept declining and declining and [she kept] postponing [the delivery]. But it really got to the point that she was going to die. And I actually told her that. I said, "You know your kidney function is starting to go and if you die the babies die; it's just that simple. There's no glory in that."

So she had a C-section. One of the babies was much smaller than the other baby and had—I don't remember what kind of hemorrhage, it doesn't matter—lots of blood in his brain, lots of blood. They were twin boys. And I still remember their names. I can even tell you his name. Isn't that funny? And he wasn't doing well and the bigger baby was doing better. And so I had been in—I remember so clearly—I was working in the MICU as an intern—and we didn't have work hour restrictions, it wasn't for sissies like they are now—it was long hours and it was hard hours and it was hard work and I was tired.

And I remember one Friday I was going to have all day Saturday off. And it was Friday evening. I got a call from one of the ICU nurses that said, Miss so-and-so is here and she's just totally flipping out and she says she has to see you. So I asked the nurse what was going on and she said, well, you know the doctors were talking to her about withdrawing support from—she used the baby's name—and she just flipped out and said, "No, there's no way I'm going to do that." And she has to see you. She's crying and she says she has to talk to you.

I had my kids. My husband was . . . I don't know where he was. So I brought two of the three kids with me that I had at the time because there was nothing to do, so I drug them up [to the hospital]. And we were walking up into the hospital and kind of in the bushes I heard, "Dr. Woods, Dr. Woods," and she was hiding in the bushes smoking a cigarette. And her family was back there with her. And she's like, "Don't be mad at me that I'm smoking."

I thought, "Oh please, that's like the least of it. I'm not going to worry about you smoking."

She was grieving and was almost violent with her crying. And I can understand how the nurses were saying she was flipping out. Although I thought she was handling it beautifully because of what she was being asked to decide. She said, "I just can't let him go, I can't let him go. I know he's sick but I can't let him go."

Her first name's Charlotte I don't think she'll mind that I shared that. I said, "Charlotte, why not?"

And she said, "He's not baptized, he won't go to heaven."

How easy is that to fix. I mean shit! So I asked her, "What is your church?"

And I called the chaplain and the Catholic priest beat us up to the ICU from wherever he was. I don't know where he was but by the time we got mom back up to the room and calmed down and got to the ICU he was there. And we all stood in the ICU and prayed and he baptized the baby and she withdrew support later that night. She held him while he died.

Every year she lets a white balloon go on Nathan's birthday, the little boy who lived . . . Because she was so cognizant, so young but so cognizant of wanting . . . She said, "I want to celebrate Nathan's birth, I don't want him to be saddled with grief on his birthday."

And she came up with this ritual. They go to the beach and that's what she started doing when he was—I am going to cry telling you this—when he was a year old.

And later I had a miscarriage, and I don't know how she found out about it but she came into clinic one day and she brought me this little plaque. And it got lost in the storm. It was down in the clinic here and I don't know where it is. It had a little poem, you know like one of those little chintzy things at the grocery store, the convenience store. But it was a little poem about a mother's love. And it came with a card that said, "You were there when my baby died, I'm going to be there for you since your baby died."

And so Charlotte is the reason now I ask everybody that has any issues, do you want this baby baptized. That's how that came up—because it was such an easy fix, and nobody had asked her why. They just assumed she was being a nutty mom. She was violent. I mean, she was hitting her husband and not in the mean, like punching but just that pissed-off-at-the-whole-world kind of way that she deserved to be. But nobody asked her why.

Woods' narrative is filled with emotive content. She addresses overt aspects of religion in birth through the idea of infant baptism. Though she is not Catholic, or even Christian, Woods understands and acknowledges the importance of religion to her patient, and is able to cater to her religious needs overtly. On a deeper level, the story articulates a mutuality of emotional need through the description of Woods' miscarriage. The story spans several years, and it integrates a difficult emotional experience into the spiritual life of both patient and provider. Stories like Woods' illustrate the range of emotional and

spiritual elements that providers can articulate when they are freed from the conventions of traditional obstetrics genres. Facilitating the telling of these stories can benefit both patients and providers in hospital based maternity care settings.

Chapter 4:

Power, Control, and Feminist Critiques of Obstetrics

The power and presence to preside over one's own birth [is] important to the definition of a good birthing experience.[1]

- Anne Drapkin Lyerly, MD, FACOG, "Shame, Gender, Birth," *Hypatia, 2006.*

You have to have a shared vision. It's anachronistic to read 1972 literature today. What Dr. Bradley was saying is that you can't trust your provider . . . When I say, 'start pitocin' and somebody looks at their doula, it is over.

-Kevin Feldman, MD, FACOG

It's important to recognize this as a process of surrender.

-Jane Rogers, Doula

Issues of power and control are often in the forefront in feminist critiques of American childbirth.[2] In their less nuanced forms, these critiques convey obstetrics as an oppressive tool of patriarchal control over women and their bodies, and obstetric technology as a professional tool for securing status and authority for obstetricians. Barbara Ehrenreich makes this argument in the classic rhetorical style of second-wave feminism in her early 1970s pamphlet, *Witches, Midwives and Nurses*. She describes how, starting with the inappropriate use of forceps, the male medical profession used

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[1] Anne Drapkin Lyerly, "Shame, Gender, Birth," *Hypatia* 21, no. 1 (2006): 111.

[2] Barbara Ehrenreich, *Witches, Midwives and Nurses: A History of Women Healers* (London: Compendium, 1974); William Ray Arney, *Power and the Profession of Obstetrics* (Chicago, IL: University of Chicago Press, 1982); Barbara Ehrenreich, *Complaints and Disorders; the Sexual Politics of Sickness*, 1st ed. (Old Westbury, N.Y.]: Feminist Press, 1973); Karin A. Martin, "Giving Birth like a Girl," *Gender and Society* 17, no. 1 (February 2003): 54-72.

technology to take control over birth, appropriating a power that rightly resides with birthing women and their female midwives:

> Male practitioners . . . led the assault, . . . claiming technical superiority on the basis of their use of the obstetrical forceps. . . . In the hands of the barber surgeons, obstetrical practice among the middle class was quickly transformed from a neighborly service into a lucrative business. . . . Female midwives in England organized and charged the male intruders with commercialism and dangerous misuse of the forceps. But it was too late—the women were easily put down as ignorant "old wives" clinging to the superstitions of the past.[3]

In the years since Ehrenreich penned her incendiary pamphlet, academics have made more nuanced appraisals of the role of obstetric technology. Judith Leavitt, for example examines the role of first-wave feminists in advocating *for* hospital-based birth with increased technological intervention, particularly in the case of anesthesia.[4] However, among childbirth activists, advocacy is still very much informed by a critique that characterizes obstetrics as an oppressive institution of patriarchal control, obstetric technology as a tool for maintaining control and securing power, and obstetricians as the undeserved beneficiaries of female sacral and political power.

Partly as a consequence of this critique, childbirth activism over the past thirty years has focused on birth as a locus for female empowerment via the active and informed rejection of obstetric technological intervention that is seen as both unnecessary and potentially physically and emotionally damaging to women. Unfortunately, this reaction fails women, both as patients and as providers, on several levels. From the patient perspective, the ideal of active rejection of obstetric technology takes for granted a power dynamic that does not characterize the doctor-patient or midwife-client

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[3] Ehrenreich, *Witches, Midwives and Nurses*.

[4] Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750 to 1950* (New York, NY: Oxford University Press, 1986).

relationship, and often sets up an adversarial relationship between the maternity care provider and the pregnant woman. From a provider perspective, the critique does not acknowledge the importance of spiritual and emotional fulfillment for obstetric providers, particularly in terms of the strains that some female providers who are also mothers experience in trying to balance these two roles.

This chapter will deconstruct the mainstream feminist critique of American childbirth from the perspective of hospital-based maternity care providers, relying on interviews with doulas, midwives, and physicians. The first section will focus on ways in which patient attempts to control birth can result in a marginalization of spirituality in the birth room via the creation of provider-patient mistrust. The second section will problematize the characterization of obstetricians as controlling and masculinist, pointing to the increasing number of female and feminist obstetricians and suggesting the spiritual, emotional, and physical health of (often female) obstetricians as an important and neglected locus for feminist scholarship in birth.

Section one examines two major interventions from childbirth activism: birth plans and doulas. When they are created and applied sensitively, birth plans can enhance the birth experience for patients. Similarly, doula labor support can have innumerable psychological and physical benefits. However, both these common interventions can also serve as attempts on the part of patients to control the out-of-control process of birth. An irony can emerge when natural-childbirth-oriented education classes malign obstetric attempts to control birth through the misapplication of medical technology, while simultaneously advocating control by creating an overly-scripted birth plan or placing the doula in the role of physician antagonist and barrier to technological intervention. Patient-physician conflict can result when patient desire to control birth leads to mistrust

in the doctor-patient relationship, diminishing the possibility for a spiritually fulfilling birth experience.

Section two will examine the intersections between power and control over birth and unsustainable work expectations for physicians. Obstetrics is a highly demanding specialty, and the inability to acknowledge the human limitations of obstetrics providers leads to spiritual impoverishment for providers as well as inhumane patient care. Ultimately, the lack of focus on the spiritual and emotional lives of obstetricians leads to less complete and sustaining patient care.

POWER AND CONTROL IN CHILDBIRTH ACTIVISM: BIRTH PLANS AND THE ROLES OF DOULAS

Writing a birth plan and employing a doula are two activities commonly suggested for the empowerment of women who decide to give birth in hospitals. The subject of doulas and birth plans came up so many times during my initial interviews that I added pertinent questions about doulas and birth plans to my later provider interviews.

A birth plan is a document created by a pregnant woman and her support person that describes the desired course of her upcoming birth. The document is intended to be distributed to her physician and to the hospital staff. Birth plans are highly variable, and can include anything from a couple's desire to have certain music playing or to have particular lighting, to a patient's or couple's feelings about pain management, to instructions on the patient's behalf for the avoidance of interventions like episiotomy or pitocin augmentation.[5] Since most hospital births involve routine interventions, the hope is that having a birth plan that articulates a desire for a different set of interventions and

[5] For a sample birth plan from pregnancy today, a popular website aimed at pregnant women, see Appendix C.

events will make the hospital staff more likely to help a laboring woman enact the birth experience she desires.

A doula is a non-medical professional childbirth attendant. Coined in the 1980s to describe women who assisted women who had just given birth with breastfeeding, the term *doula* now describes a person, usually a woman, who provides emotional, physical, and informational support to a woman during labor, the postpartum, and sometimes the prenatal period.[6] A doula's role is to support the laboring woman through the birth, and doulas often provide prenatal and postpartum physical and emotional support for the mother and baby as well. Women usually hire doulas independently, often paying them out-of-pocket; however, doulas are also sometimes employed by hospitals, midwives, or groups of physicians. Doula training is variable, but many doulas are certified through the organization DONA (Doulas of North America) International, which requires candidates to complete an academic component as well as practice clinical childbirth experience and observation.[7]

While the role of a doula is technically that of a specialist in labor support, a role that obstetrician-gynecologist Melanie Saunders referred to in our interview as "mothering the mother," doulas often wind up playing multiple roles, some of which conflict with the beliefs and desires of the medical community.[8] One theme that emerged in my interviews was the role of the doula as the physician's adversary, most commonly in advocating against interventions the physician desired but that were perceived as unnecessary by either the patient or her doula.

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[6] Karla Papagni and Ellen Buckner, "Doula Support and Attitudes of Intrapartum Nurses: A Qualitative Study from the Patient's Perspective," *The Journal of Perinatal Education* 15, no. 1 (2006): 11-18.
[7] "DONA International – Birth Doula Certification," http://www.dona.org/develop/birth_cert.php. (Accessed March 21, 2011)
[8] Melanie Saunders, [pseudo.], interview by author, audio recording, 30 August 2010.

Partially as a result of this perceived adversarial role, attitudes towards birth plans and doulas vary widely among maternity care providers. As army physician Mark Blake told me of his training, "In residency it was always a joke that if you have a doula or if you have a birth plan, that means c-section. That means things are not going to go right."[9] Although later in his career Blake warmed to these practices, saying, "Over time I realized that people are just wanting the best experience they can have for their pregnancy and delivery," doulas and birth plans initially represented to him both unrealistic expectations for labor on the part of the patient and an adversarial relationship between the doula and the health care team. The rationale of the provider was that this combination of factors would likely result in the opposite of the desirable outcome, a surgical delivery in the form of a cesarean section. Most medical literature contravenes this belief, suggesting that in addition to patients in randomized studies reporting a great deal of satisfaction and emotional benefit from doula support, the presence of a doula actually decreases the rate of cesarean as well as that of other medical interventions.[10] But despite its factual inaccuracy, the perception that the desire for a different kind of birth experience is likely to lead to a cesarean section is a common belief among obstetric care providers that warrants examination.

Although any woman can use a doula's services, doulas are often associated with women who wish to avoid technological intervention or epidural anesthesia. Because the presence of a birth plan or doula typically connotes that a woman wants a different kind of birth than what is usually provided in a hospital setting, it is perhaps unsurprising to hear a negative attitude towards doulas and birth plans from a physician like Blake, who

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[9] Mark Blake [pseudo.], interview by author, audio recording, 25 May 2010.
[10] A. L. Gilliland, "Beyond Holding Hands: The Modern Role of the Professional Doula," *Journal of Obstetric, Gynecologic, and Neonatal Nursing* 31, no. 6 (11, 2002): 762-769.

does not identify with the mainstream feminist critiques discussed earlier in this chapter. More surprisingly, however, criticism of birth plans and the sometimes adversarial role of doulas also came from physicians who strongly identified with childbirth as a form of female empowerment, midwives, and even doulas themselves.

While every interviewee was familiar with doulas and birth plans, and the great majority reported being able to work with patients who employ them, there was also a fair amount of critique, even from physicians who considered themselves to be open to non-traditional births. One example is Karina Neiman. An obstetric intern with a master's degree in anthropology under the supervision of Davis-Floyd, Neiman has done extensive work both in social-sciences research and political advocacy supporting midwifery model care. She said:

> *I spent a year in Mexico working with traditional midwives and seeing if we could integrate them [into the hospital system there]. Rachel*[11] *is great [but] 80% of doulas do not understand the role of a doula. My experience on this side is that doulas come in with a very defensive stance like I'm going to stop you . . . and it's motherfucking annoying and it already sets up an adversarial relationship. And because of that experience with the other doulas, I even find myself, me,* me*, hearing that the patient has a doula and a birth plan and rolling my eyes.*[12]

Doulas themselves sometimes criticized birth plans that they viewed as overly long or specific. Rachel Marini, for example, whom Neiman mentions in the above quote, opined to me, "make a birth plan and watch God laugh," preferring to refer to it as "the birth wish list." Kevin Feldman, who emphasizes the importance of birth as a transition rite and employed Marini as part of his hospital-based practice, likes to refer to the document as, "the birth fantasy," suggesting that the importance of the birth plan is for the physician to understand the general character and desires of the couple, rather than to

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[11] Neiman is referring to Rachel Marini, one of the doulas I interviewed.

[12] Karina Neiman [pseudo.], interview by author, audio recording, 17 February 2010.

have specific events dictated to her.[13] And obstetrician Melanie Saunders, whose practice is "very accepting of doulas," and who expressed enthusiasm for "the concept of mothering the mother," also had reservations, saying, "I don't like people to get hung up on the right way of doing things because no one knows [what will happen in a delivery], and so I worry about people having this construct that they have to follow when they're in labor."[14] Saunders continued:

> *You need to get out of the way of your body. Let your body do what it needs to do. And it doesn't matter where you do that. You can do that so easily in the hospital, you can do that at home. You do need to let your body go.*

For Marini, Feldman and Saunders, the problem with a specific birth plan hinges around its unattainable ideal of control during birth. Each highlighted the impossibility of predicting exactly how a birth will progress.

Furthermore, both Saunders and Marini suggest that the uncontrollable nature of childbirth is closely related to its spiritual and religious aspects. Marini, who now works as a home birth doula, even echoed the attitude that Blake's superiors taught him in his residency training, saying, "The longer the birth plan, its like, 'get the OR ready, because this person is about to be taught a very valuable lesson in life.'" According to Marini, the spiritual aspect of birth was intimately tied to the loss of control a woman and her providers experience during the birth. Whether hospital-based patients sought to control birth through access to high-tech medical care or by detailing a highly specific birth plan, attempts to control birth are ultimately unsuccessful because they fail to acknowledge the risk of disability and death. Marini said:

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[13] Kevin Feldman [pseudo.], interview by author, audio recording, 14 February 2010.
[14] Melanie Saunders [pseudo.], interview by author, audio recording, 30 August 2010.

> *That's the part that makes it spiritual, you can't guarantee when you're going to die, or if you can stay alive . . . we just don't have control over those things in life. A lot of people are scared to talk about it. People in the hospital are going to want to be guaranteed a safe outcome. They go there for the perceived notion that they're going to have a safer outcome and everything will be fine, and it's not necessarily true.*[15]

Marini acknowledges the necessity of giving up control in birth, but also identifies it as a frightening and difficult process and acknowledges the threat of death as a vital element of spirituality in birth.

Family physician Patricia Woods also made a connection between birth and death, working from the perspective of medical intervention as an attempt to control birth. She said:

> *As a society we have moved away from honoring death personally. In our society people die in the nursing home and in the hospital and we push it away. As physicians we can't push it away all the way, but we can medicalize it. We can make algorithms and protocols and all sorts of things. We can pretend that we have knowledge, and we have [technical] words, and we know what to do. I think that's what we do in labor and delivery too, and that's what we do in codes. When you really look at it, I mean, if somebody is going to die, they're going to die. And we can dance around it and do all the things, and maybe postpone it a little, but they're going to die. And the truth is if a baby is going to be born it is going to be born. I mean, it is time. And we don't have control. And we can label it, say it's too long, too short, all those things, but the truth of the matter is we don't have control. And I think we like the illusion of control. I think we like to have this feeling that we can somehow control these huge transitions in life, which in reality we can't. And I think many people are uncomfortable with that.*[16]

The connection between the out-of-control nature of birth and death and an experience of birth as a spiritual or life-cycle event was common in my interviews. For many subjects, the fear of death was intimately related to issues of spirituality in childbirth. Marini suggests that despite major advances in maternal and neonatal morbidity and mortality,

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[15] Rachel Marini [pseudo.], interview by author, audio recording, 17 February 2010.
[16] Patricia Woods [pseudo.], interview by author, audio recording, 25 March 2010.

the major source of fear and anxiety among women in childbirth is still the threat of death or disability:

> *The spiritual aspect in it [is this]. If you ask any pregnant woman to be honest, truly honest. I always ask my clients what are you most afraid of. If I get them to be really really honest [they say], "I'm sure the baby's going to die, [or] there's going to be something wrong with the baby [or] I might die in labor." And there are no medical advances to this date that can guarantee a healthy outcome. Sure we have a lot less bad outcomes, but I feel like there's that moment of "you're really taking that big huge step," and sure, thank god 99 percent of the time it goes just fine. But it doesn't matter. And when it is fine, there's that buildup of anticipation, and then it's fine, and you've just had a human being come out of your body!*

Marini's statement is interesting because in addition to pointing out the bodily vulnerability that childbirth engenders, she also identifies that very vulnerability as the source of spirituality in childbirth. The fear of death and disability that her clients describe when "I get them to be really really honest" *is*, "the spiritual aspect in it." This is a point that bears some belaboring, particularly when we remember that the cornerstone of the Midwives' Model of Care lies in its insistence on viewing childbirth as a non-pathological, normal life-cycle event that should not be feared or medicalized. To some degree, the Midwives' Model rests on a body of literature that characterizes obstetric technology as a largely inappropriate co-opting of what is generally a safe and normal process. Karin Martin summarizes this as the argument that "the medical system interferes with a process that is safe and natural and not in need of medical management."[17] And while the overwhelming majority of midwifery practitioners agree that access to emergency obstetric care is a great boon for contemporary Western women, the great divide between birth activists and mainline obstetrics hinges on the question of risk in childbirth. In order to make the argument that childbirth without technological

[17] Martin, "Giving Birth like a Girl," 55.

intervention is generally safe, indeed safer than childbirth with unnecessary intervention and the attendant risk of iatrogenesis, childbirth activists use their own spiritually-inflected terminology: midwife Margaret Heinley along with several of my patients, referred to the belief that childbirth is a safe and natural process as having "faith in childbirth."[18]

In addition to causing a substantial amount of polemical and sometimes vitriolic debate, the ideal of childbirth as "safe and natural and not in need of medical management" sometimes forecloses a provider's opportunity to address patient anxieties about pain, suffering, death and disability—anxieties that women often experience during pregnancy and birth, and which are highly related to the spiritual and religious elements of birth.[19] Meredith Marshall, a young woman whose birth story I will examine in detail in Chapter 5, described feeling unprepared for her difficult birth after taking a Bradley method childbirth class. Marshall's birth involved a great deal of pain and suffering and ultimately ended in cesarean section. She said:

> *We took Bradley classes I think. We had an instructor—I didn't read the book, I don't actually know how much the instructor stuck to Bradley methods—and she had been through natural childbirths, and I'd had friends who had also done natural. I had a lot of friends who tried, ended up with epidurals. I definitely had sort of been indoctrinated into the idea that if it's natural then you won't have the drugs and then the baby will crawl up your tummy and suckle and it won't be all drugged up. And there's just a lot of things people will tell you. And I do firmly believe that we were created to be able to birth without medical intervention. Or*

[18] Margaret Heinley [pseudo.], interview by author, audio recording, 12 May 2010.

[19] For an excellent example of the antagonistic tone these debates can take, see physician-anthropologist Lewis Wall's particularly condescending response to anthropologist Alma Gottleib's article about her own birth at a hospital after her fieldwork with the Beng. Lewis Wall, "The Anthropologist as Obstetrician: Childbirth Observed and Childbirth Experienced," *Anthropology Today* 11, no. 6 (December 1995): 12–15; Alma Gottlieb, "The Anthropologist as Mother: Reflections on Childbirth Observed and Childbirth Experienced," *Anthropology Today* 11, no. 3 (June 1995): 10-14.

> *otherwise we wouldn't be here still. So I had of faith in [birth] just like I shouldn't have had . . .* [20]
>
> *I didn't have any risks during the pregnancy, or any other factors that would've made me concerned. So I think I really just wanted to . . . I had a very comfortable confidence that people could. . . that there would be no reason that it couldn't happen naturally, that it was just going to be hard. . . . I'm a big scaredy-cat with pain so I was really nervous about that part. That's why I went to the birthing center, because I was worried if I started in the hospital I would accept the drugs that they were offering, that I wouldn't even really get a fair chance of doing it naturally. So I went somewhere where I knew it would be hard to transfer. I would not do that again. Because at point there's no . . . Like, I wish I hadn't been so exhausted for the final product. There's a tradeoff where someone who wasn't so miserable and worn out by the end probably would have enjoyed the first couple days with their baby more. But at that point I was anemic from blood loss, I was extremely swollen from being on IV for two days, I was just exhausted. So I don't think I really reaped all the rewards I was expecting to reap by doing it that way . . . I just didn't really think there was any reason why it couldn't happen.*

For Marshall, childbirth education classes did not prepare her for the possibility for a birth that ultimately ended in surgical intervention, leading to feelings of failed expectations.

An inability to acknowledge women's fear of death and pain also closes off a major possibility for spiritual insight and experience in pregnancy and birth. In pursuit of the laudable goal of making childbirth more humane for women, families, and babies, the Midwives' Model runs the risk of overlooking a major source of both anxiety and spiritual fulfillment in birth: vulnerability to pain, disability, and death. Heinley described how her faith in childbirth worked as both an asset and an impediment to providing humane, spiritually sensitive maternity care. She describes:

> *What I have is this really strong faith in childbirth, and to a fault almost. I didn't understand why people didn't want natural childbirth. I had to kind of come around to that, to understand why people would be terrified of that and how should be their right to use pain medication and stuff like that. That took a little*

[20] Meredith Marshall [pseudo.], interview by author, audio recording, 18 March 2010.

> *while, to realize the way I'm built, my beliefs, the way I came to be who I am—that's not where everybody else is at. That was a maturity thing.*

As Heinley points out, in order to incorporate spirituality as an aspect of humane maternity care, a practitioner's model of care must be flexible enough both to allay a patient's anxieties about her pregnancy when they are unreasonable and simultaneously to recognize and accommodate her very natural fear of vulnerability.

In addition to the importance of recognizing the risk of death and vulnerability as critical aspects of spirituality in childbirth, providers and patients both talked about surrender during birth. Doula Jane Rogers suggested an inverse relationship between suffering and surrender when she described her own birth, which started at home and ended in the hospital:

> *I knew this was not going to proceed the way I wanted it to. It wasn't about wanting. This was about surrender. When I finally got that this was about surrender . . . I was finally okay with it. And that's what can create a lot of suffering for women, and could have created a lot of suffering for me, is grasping for an outcome. I was grasping at trying to affect an outcome, I was grasping at my home birth. I wanted my baby at home. And when I stopped grasping the suffering ended . . . I walked into the hospital fully aware, fully capable, and totally surrendering. At that moment I wanted my baby in my arms, I was hungry for it. And at that moment I would have done anything. I was okay with having a cesarean. And I knew that that moment, if I had a cesarean, was not going to define my birth. My birth was so much more than that. And later when people ask about my birth. I tell them that I distinctly had two births. I gave birth to myself as a mother at home [and I went to the hospital to have my baby].*[21]

For Rogers, "grasping at . . . an outcome," is what created suffering for her in her birth. This idea is relatively unique in the feminist childbirth literature, which tends to associate unnecessary medical intervention with women's suffering. In contrast, for both Marshall and Rogers, attempts to avoid medical intervention caused a great deal of suffering. As Rogers describes, "grasping at an outcome," whether by unnecessary technological

[21] Jane Rogers [pseudo.], interview by author, audio recording, 15 June 2010.

intervention on the part of the obstetrics establishment or by a failure to acknowledge the importance of surrender during birth, can cause suffering for women.

Several providers made a connection between surrender during birth and the process of childrearing. Saunders put it this way:

> *I always say that it would be good if you recognize this as a surrender, this is a process of surrender and that you have to allow it to happen, you can't make it be a certain way. You can do things to prepare yourself, but you still . . . have to surrender. Just like you surrender to your child because they're going to have their own way in the world and you're just . . . there to guide them. You don't know.*

For Saunders, the ability to surrender to the process of birth was an important first lesson in parenting. Samantha Percival expressed a similar sentiment using more overtly spiritual language. The desire to control birth via obstetric technology does not always come from the provider side. Percival, whose practice includes many patients who are devoted to the idea of natural childbirth, often has to convince her patients *not* to induce labor when it is not medically indicated. She said:

> *There is a huge amount of letting go of control, and realizing that there is a greater power in the world, of which we have no control. And people have such a hard time with that. And it's interesting because even of those people who are very natural birth devoted, you can see the work that women have to do to really grapple with that concept. [To realize], this baby is deciding. This life that is growing within me gets to decide when it's going to come out. And I may be feeling really uncomfortable and miserable right now but I still don't get to decide. And we don't let them decide that, unless it's a true medical emergency . . . That is so counter to our system. . . I think that is incredibly powerful.*[22]

Percival also made the connection between parenting and letting go of control during birth:

> *I think that it's wonderful from a parenting perspective. I think it is such a vital lesson to learn to let go from the get go . . . just realizing that there is so much*

[22] Samantha Percival [pseudo.], interview by author, audio recording, 13 June 2010.

> *about which we have no control. And whether or not you interpret that through a spiritual frame of reference, or through some other frame of reference, I think that being able to let go like that really helps one parent. Because you can't control their spirit either. You can guide it and try to help shape it, but you really can't control it. And I think the more we try to do that as a society the more out of touch we become with . . . what we don't control. And probably with our spirituality.*

Percival's comment points to an aspect of excessive obstetric intervention in birth that often goes unrecognized: both patients and providers try to control the process of birth. This can take the form of patients requesting unnecessary obstetric interventions, like elective induction or cesarean section, and, as we will see in the next section, can also manifest in an unrealistic (and sometimes unsafe) attachment to the ideal of natural childbirth, as Percival describes, "at all costs."

Power and Physician-Patient Conflict

Even feminist obstetricians (a term Rothman once described offhandedly as "an oxymoron") sometimes face difficulty in engaging with patients who are steeped in the critique of biomedicine common in feminist childbirth literature, a critique that characterizes obstetric technology as unnecessary, dangerous, disempowering, and oppressive to birthing women. My obstetrician interviewees in particular vocalized their dedication to childbirth as a potentially empowering experience for women alongside an anxiety about perceived excesses in patient control over medical decisions. Physician interviewees expressed anxiety, discontent, and even anger when patients tried to gain control over the birth process in ways that they perceived as frustrating and sometimes dangerous.

This anxiety derived not so much from any discomfort with declining professional power per se as from two common situations. First, physicians experienced a great deal of anxiety when their patients rejected medical interventions that they saw as necessary to

ensure the safety of the patient and her baby. Second, they resented the negative psychological and emotional effects of patient mistrust on the physician-patient relationship. Ironically, physicians who identified patient empowerment as an important aspect of birth often had more difficulty with patients who made medical decisions perceived as unsafe than physicians who did not identify patient empowerment and choice as a goal. This was likely because patient empowerment practices gave patients more opportunities to make decisions that were perceived as dangerous. They also tended to attract patients who mistrusted the medical establishment but had pathology that made them ineligible for a home-birth. The latter was a particular problem for the practice of Samantha Percival and Marilyn Watson. Because they provide the only hospital-based midwifery service in their progressive city, their practice often attracts patients who desired home birth but had complicated pregnancies that required medical attention. They also have one of the few practices in their metropolitan area that actively avoids several common obstetric interventions, and are willing to attempt vaginal delivery in some cases where scheduled cesarean section is common (for example, twins). This means that Percival and Watson sometimes attract high-risk patients who would otherwise have opted for a home birth. Some of their patients, having been referred to their practice by home-birth midwives for pathology that necessitated intervention, were very suspicious of the increased level of technological access that brought them to a physician in the first place. Percival described one patient in her practice who had diabetes, a disease that can lead to stillbirth and other neonatal morbidity. Induction at 39 weeks is common in diabetics because of the risk of placental insufficiency and macrosomia (babies that are very large) that can result in stillbirth. This patient was scheduled for a 39-week induction, but did not show up to the hospital when it was scheduled:

> *We [had one patient] with Gliburide dependent diabetes, who refused a 39-week induction. She said she had a family emergency and then did not show up for her induction. She didn't go into labor until 41 and a half weeks.*[23] *Every time we would see her it was excruciating. [We would recommend induction, and she would say,] "I don't agree with you, I don't believe you, I think my baby is fine and I want my labor to start on its own." And we were thinking, "Gosh, we agree with you, we want your labor to start on its own too, but we don't want your baby to die. Your placenta [can develop insufficiency]. The reality of diabetes in pregnancy is that it's unpredictable. We can't guarantee [what will happen.]" And as a mother I can't imagine [that mentality] . . .*
>
> *[In addition to the physical risk], there's also the awful tone that that birth takes, if you can imagine the most awful, unpleasant energy imaginable, that's the tone that birth takes. And that's no good for the mom.*

Percival and Watson, like Kevin Feldman, each emphasized their discomfort with the way that power and control is treated in childbirth activism in situations where they felt the patient's desires to avoid technology infringed on safety.

The physician-patient relationship also suffered in such situations, leading to frustration and discomfort for even those physicians most dedicated to patient empowerment. Percival's and Watson's practice, which is "bursting at the seams" with patients, emphasizes the importance of patient choice, empowerment, and a holistic approach to maternity care. Percival, who started the practice, describes it as "pro-choice in the complete sense of the word," meaning that her practice advocates for the patient's ability to choose her birth location, home or hospital. Despite expressing the importance of patient empowerment in birth, Watson also expressed her frustration with patients she felt were overstepping the important boundaries in the doctor-patient relationship. She said:

> *Patients think they know more than us and can set their own rules in the hospital. And we are the opposite of a paternalistic practice. We are a patient empowerment practice! But people can still push those lines. They flat mistrust us.*

[23] A week and a half after term.

> *You can't have a therapeutic relationship if there's that kind of mistrust, you know if they're calling all the shots.*[24]

Watson's statement is a reiteration of Kathryn Montgomery's idea that the power imbalance in the doctor-patient relationship is intimately related to its efficacy. The physician-patient relationship is one of unequal power that depends on trust for many of its therapeutic effects. Watson's statement that "You can't have a therapeutic relationship" if the patients are "calling all the shots" underscores the importance of a relationship in which each partner has power in a different arena. A physician-patient relationship in which the patient makes *all* the medical decisions is inappropriate, according to Watson. Such a relationship is fundamentally broken, because it is no longer a relationship of trust. At its best, the doctor-patient relationship is one of vulnerability and trust, rather than a relationship between two autonomous colleagues with equal power and knowledge. And while, as many critics have appropriately pointed out, patient trust has often been misplaced in the hands of physicians who (whether intentionally or not) abused it, the fact remains that the therapeutic relationship, the relationship that is the cornerstone of medical practice, cannot function well without trust.

Percival describes her discomfort in treating patients who are deeply mistrustful of the medical system. She said frankly:

> *We have some crazy patients. There are some people who take natural birth to an extreme, where it really is vaginal birth at all costs, where we have to spend all day charting that advice was given and refused . . . Those are awful, and they happen with some frequency. And as an obstetrician and a mother I have a hard time with that because I can't begin to imagine what is going through that person's mind [when she refuses medical care that might prevent a terrible outcome]. There's a piece of it that is just an enormous distrust of the medical system, so even when we come to their care from a very careful perspective it doesn't matter because they have developed such deep-seated mistrust that it*

[24] Marilyn Watson [pseudo.], interview by author, audio recording, 13 November 2010.

> *doesn't matter because we're still part of the medical community and what we say can't be trusted.*

Percival went on to describe this patient mistrust:

> *The biggest struggle that we've had as a practice [has been] how to deal with those circumstances, and how not to let those circumstances drain us as individuals completely dry. Those patients suck the life out of you. By far those are the worst experiences that we have . . . these people are taking years of life off my life.*

Though Percival was generally very measured in her responses, her reaction to these situations was highly emotional, denoting the extreme anxiety that she feels with such patients.

Feldman, a physician who is well respected by the doula he employed, and whom I witnessed attending one of the sweetest and most respectful deliveries I have seen in my training, dealt with these conflicts in a more strident fashion. He reiterated several times in our conversation that respect for patients did not mean giving them control over medical decision making. Feldman said:

> *I have no qualms about saying, "No, you know what, you may want that, but I'm in charge. People think I'm very lefty.*[25] *You know what? Patients don't have the right to make medical decisions. I make medical decisions. Patients make decisions about aesthetics. They don't get to decide if they have a C-section, I decide if they have C-section. That's why they come to me. They can refuse; I'm not going to assault them . . . But . . . If I tell them [they need a forceps delivery or a cesarean section], it's because I in my medical opinion think that's the right thing for them. It's not like, "What do you think about forceps?" I'm a medical expert in the field. . . . You know my leftiness is about creating mood, tone, aesthetics, and helping them understand this as a life cycle and helping them to view [birth] through that prism.*

Feldman suggests that the appropriate physician-patient relationship involves a balance of power in which patients make decisions in the field in which they are "experts" (what he

[25] Feldman referred to his identification with the alternative birth movement and his emphasis on mood and tone in birth and the importance of birth as a life cycle event as his "leftiness," a reference to the left-wing, or liberal ideology.

describes as the realm of "aesthetics"), and physicians make decisions about when medical intervention is appropriate. Feldman is an interesting example of someone who identifies very strongly with the idea that birth is an important transition rite, but does not promote the importance of patients actively rejecting technological intervention against the advice of their physicians. Like Percival and Watson, Feldman emphasized the importance of trust in the doctor-patient relationship and the ways in which common childbirth-advocacy interventions can work to erode that trust:

> *Sometimes it needs to be said up front, I'm never going to say to you, "Do you think you need a C-section?" And sometimes that is startling for them . . . When patients say, "Well, when do you do C-sections?" I'll look and them and say, "You would like an exhaustive list of when I do C- sections? Well, I trained for eight years to do that. That's quite a complicated question. What are you asking me? . . . Are you asking me a question because you want to know whether or not I know, or because you're scared whether or not I do it for the right reasons?* Are you trying to take a history about whether or not you trust me? *Because let's try to get to the bottom of what your question is. Because that's not a question. Because you don't know the answer to that question. So where are you going?"* [Emphasis added]

Because of the excessively high American cesarean rate, and the common practice of performing cesarean sections in cases that contravene clinical evidence, women are commonly advised to ask potential obstetricians when the doctor will perform cesarean section. As Feldman points out, this kind of strategy is limited in two ways. First, it assumes a degree of medical knowledge that a layperson cannot reasonably be expected to have. The indications for cesarean section are extremely complicated and require a great deal of specialized knowledge to understand—as he puts it, "eight years" of medical training. The expectation that a patient, even a highly educated and well-informed patient, will have the same knowledge base as an obstetrician is unrealistic. Second, the question evinces a relationship of mistrust between physician and patient. Feldman characterizes the process in medical terms, using the metaphor of the case history, but

placing the patient in the role of history taker. He says, "Are you trying to take a history about whether or not you trust me?" Feldman's critique points to a major flaw in many critiques of obstetrics—they assume a relationship of mistrust between obstetrician and patient as an appropriate response to the current state of obstetric care. While this might be an appropriate conclusion in light of the prevalence of many unnecessary technological interventions, it is also an unsustainable model for the therapeutic physician-patient or midwife-client relationship. Simply managing to avoid medical intervention in birth does not guarantee a spiritually and emotionally fulfilling birth experience. As Feldman suggests, "You have to have a shared vision."

This section has focused on destabilizing the mainstream feminist critique of obstetrics from the perspective of spiritually fulfilling birth experiences for patients. The next section will focus more directly on physicians, looking at the increasing number of female and feminist obstetricians and pointing to the importance of emotional and spiritual fulfillment for providers as an important and neglected aspect of feminist scholarship on birth.

FEMINISM AND PHYSICIANS

Samantha Percival believes passionately in the importance of birth as a locus of empowerment and fulfillment for her patients. Among the four midwives and two obstetricians in her practice, the personal commitment to this ideal is palpable. She spoke about the providers in her practice:

> *Of the six of us, five of us have kids. And the five of us who have kids all birthed naturally. So we all chose as women to do what we're supporting for our patients, so that it really comes from not only a clinical belief but also a personal belief. Everybody really practices what they preach.*

As an advocate for midwifery care in low-risk pregnancies among her patients, Percival had chosen a midwife to deliver her own baby. But when she was only 33 weeks pregnant, her water broke prematurely, sending her into preterm labor. Her labor started after a particularly grueling bout of work. Percival explains:

> *As is the life of a typical obstetrician, I was working a lot. I had a lot of bleeding my first trimester and I thought I had miscarried. [But] the pregnancy continued and in my third trimester I was having contractions. Ultimately I really think that the primary responsibility for my premature birth was all the bleeding in the first trimester, which can weaken the membranes. But I worked 36, 48 hours. I worked some crazy number of hours straight [just before going into preterm labor]. I had done eight deliveries and had literally not sat down for the last 36 hours, that whole chunk of time I was just going. That was Tuesday morning until Wednesday. And I think I had been backup call on Monday too and had gotten called in on Monday. Anyway it was some ridiculous stretch of time. Then [I] came home on Wednesday night and my feet looked like tree trunks, and then got up the next morning got up on Thursday and went to work. [I] was contracting a bunch at work, and went home that night and woke up at midnight in a pool of water.*

Percival gave birth to a premature baby boy, Andrew, who needed ventilator support and spent an entire month in the Neonatal Intensive Care Unit. "Which is a story in itself, and a trial."

Percival's preterm birth exemplifies one of the greatest ironies that emerged from my physician interviews: the physicians who were most dedicated to creating a spiritually fulfilling, emotionally sensitive practice environment for their patients were the same providers who consistently marginalized their own spiritual, emotional, and even physical health for the sake of their patients.

Karin Martin gives a broad overview of the major critique of hospital birth under a technocratic system:

> According to this [feminist] critique, women lose agency in the experience of childbirth and are disempowered by its medicalization. An experience that is potentially empowering is made alienating and oppressive. In sum, male

> institutions and their technologies regulate and control women's childbirth experiences.[26]

The critique that characterizes obstetric technology as a tool for male professional power and legitimacy over women has been highly successful in terms of creating a worldwide movement that advocates for alternatives to the highly medicalized forms of childbirth common in the United States and elsewhere. It is also highly problematic in several ways. In particular, the idea that health care is a patriarchal or even male institution has become increasingly difficult to justify. A great deal has changed about obstetrics since the 1970s. Particularly germane is the radical shift in the gender balance of the profession. A rapidly increasing number of obstetrician gynecologists are women; they now account for 74 percent of all OB/GYN residents.[27] Several obstetricians even sit on the board of *Our Bodies Ourselves,* the classic women's health text first published by a feminist consciousness-raising group in the 1970s.

As women continue to thrive in the field of obstetrics, to the point that today it is not uncommon for male medical students and residents to make allegations of sex discrimination, the idea that obstetrics represents a patriarchal oppression of women becomes increasingly difficult (though not impossible) to justify. In addition to the sheer number of women obstetrician gynecologists, many of these physicians also actively identify as feminists. Obstetrician Melanie Saunders, for example, came to medicine by way of feminist activism in women's health. As an undergraduate at UC-Davis she created a model for teaching pelvic exams to medical students, worked in a free clinic, and even met Suzanne Arms, remarking, "My perspective on medicine was very much from a female empowerment, feminist perspective."

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[26] Martin, "Giving Birth like a Girl," 55.
[27] Jane van Dis, MD, "Residency Training and Pregnancy," *JAMA* 291 (2004) 636.

Contemporary feminist criticism of the field of obstetrics and gynecology must take into account the perspectives of female physicians as well as their patients. In addition to destabilizing the blunt critique that characterizes obstetricians as masculinist wielders of technology, my interviews with female and feminist obstetricians suggested that improving the emotional, spiritual, and physical health of providers is an important and neglected aspect of feminist scholarship and activism. The dual role of obstetrician as mother is a particularly important and often neglected area of study. Physician providers, particularly the female obstetricians I interviewed, consistently identified the extreme working hour requirements as their least favorite part about obstetric practice. With respect to pregnancy, this irony manifests itself in an increased rate of complicated pregnancy among obstetricians, as well as a pervasive intolerance for pregnancy among obstetrics trainees. After birth, trying to find a balance between the twin identities of physician and mother was similarly difficult for interviewees. Even without the added stresses of motherhood, the stresses of an obstetric practice often make holistic self-care difficult. Interviewees who did not have children similarly described the difficulty of instituting the holistic model of spiritually sensitive care they espoused for their patients in their own lives.

The out-of-control nature of birth, whose effects on birthing mothers were discussed in the previous section, also means that obstetricians endure some of the worst working conditions among physicians. Obstetrician-gynecologist Marti Anderson described this phenomenon:

> *Obstetrics rather than other medical disciplines requires one to drop what one is doing in an instant and respond instantly. One can't impress one's will on what's*

> *happening. One has to respond rather than dictate. I've met those who had to give up the specialty because it didn't suit their temperament.*[28]

Obstetricians have to take extended overnight calls, and the fact that the obstetrics and gynecology specialty, unlike midwifery, is also a surgical specialty makes its training program one of the most arduous in medicine. The specialty is similarly taxing after training ends. Percival spoke about the effects of these requirements on the rates of unnecessary technological intervention:

> *The lifestyle is really hard. It's really hard to do all of the nights and still get enough rest and to have time for family and self-nurture. It's very hard to do. I think that that's . . . That feeling is the start of how things go downhill for obstetricians. Over time, if you don't have some kind of structure in place to be able to break you free so you can give to self what you are constantly trying to give to others, then you start looking for outs that make it easier. Whether that's trying to induce everybody during the daytime so they don't deliver at night, or doing an unnecessary c-section on somebody. I think it's a slippery slope. And there's an expectation from your colleagues that if they're already knee deep in that culture, that you're going to do the same, because they don't want your patients to show up [in the middle of the night]. So everybody starts to work under the same construct. It's sad that more has not been done to find out, how do you preserve the purity of practice and respect the lives of the individuals who are in practice. And I still haven't figured that out. It's still an experiment.*

The lack of attention to creating livable working conditions for physicians who are also mothers thus leads directly to compromised health care for the birthing mothers who are their patients.

The difficult lifestyle of obstetricians also results in a specialty that has very little tolerance for pregnancy among residents. In her 2003 review of pregnancy during residency training, Susan Finch writes:

> The demands of residency conflict with the realities of childbearing: the age limits of fertility, the time needed to develop a relationship with a partner, the time and energy needed to carry a baby, the need to eat and sleep properly to ensure health,

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[28] Marti Anderson [pseudo.], interview by author, telephone, 21 June 2010.

> the time needed for bonding and attachment, and for breastfeeding and caring for a baby, and the availability of child care. Society sees medicine and motherhood as two separate careers that require constant attention and availability.[29]

Moreover, the medical profession still has negative attitudes toward pregnancy in residency. For example, in one study, a female obstetrician stated, "Becoming pregnant is not appropriate during this time period [residency]. If you [or they] want to conceive, they should do it on their own time and not inconvenience others." Similarly, the comment "It is unacceptable to become pregnant during residency" was made to the Advisory Committee on Equity Issues of the Royal College of Physicians and Surgeons of Canada regarding parental leave during residency.[30] The grueling work requirements of obstetric training and practice result in an increased chance of preterm labor, pre-eclampsia, and intrauterine growth restriction among pregnant obstetrics and gynecology residents, as compared with the wives and partners of their male colleagues.[31] For residents, a pervasive intolerance for pregnancy manifests itself in delayed childbearing, increased rates of pregnancy complication, increased rates of elective abortion, and infertility.[32] Complications in pregnancy are increased among practicing physicians post-residency as well.

In addition to the stresses on pregnancy itself, combining the arduous time commitments of an obstetrician with parenting responsibilities is also difficult. Priscilla

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[29] Susan J Finch, "Pregnancy During Residency: A Literature Review," *Academic Medicine: The Journal of the Association of American Medical Colleges* 78, no. 4 (April 2003): 418.
[30] Ibid.
[31] Steven G Gabbe et al., "Duty Hours and Pregnancy Outcome Among Residents in Obstetrics and Gynecology," *Obstetrics and Gynecology* 102, no. 5 (November 2003): 948-951.
[32] This trend is not limited to obstetrics residents. One questionnaire-based study of plastic surgery residents found a 57% overall complication rate during pregnancy, a 26% rate of elective abortion, and a 33% infertility rate. L Eskenazi and J Weston, "The Pregnant Plastic Surgical Resident: Results of a Survey of Women Plastic Surgeons and Plastic Surgery Residency Directors," *Plastic and Reconstructive Surgery* 95, no. 2 (February 1995): 330-335.

Stills-Blair, like many female obstetricians, eventually retired out of obstetrics and now practices exclusively as a gynecologist. She explained:

> *I will say, as a woman and when you become a mom, when you have a family, it's hard being an obstetrician gynecologist if you continue doing obstetrics and managing a family. It's hard. And that's the one downfall I'd have to say. I mean it's hard on the men, too, but I think as women we tend to feel that it's more our responsibility than theirs, right or wrong. There's just something innate in us that we tend to feel that way. And so there's a lot of guilt feelings when you haven't spent as much time as you would have liked with your child. I found my son could not move fast enough because I was always rushing. I had to get him off to school so I could get to work on time, then after school had to pick him up so I could get back, I might get called. It was just rush, rush, rush. That's the one thing I think that I do regret. And I got out of obstetrics because of my son. At the time I got out of obstetrics he was four, five, six. He was starting first grade. And so I knew that all that time that I had spent being busy and gone, because I was so busy, that I didn't want to continue doing that, especially as he got into school. When you didn't make it to his plays he'd say, "Everybody had their mom except me." Or when I'd go down to see it I could see his little head looking, "Is my mom here?" That's just natural for kids, that they want their parents there. So that was the hardest part. Because I loved what I did and I could've stayed in the hospital. When I didn't have Samuel in my life I didn't have a problem with it at all.*[33]

Physician interviewees often twinned descriptions of the difficult time commitments of obstetrics with a vocational narrative that represented obstetrics or medicine as a calling. Stills-Blair was no exception. Obstetrician-gynecologist Marti Anderson similarly described:

> *It's not convenient. It requires selflessness . . . giving of oneself. Giving up one's weekends, and evenings, and the best times of one's life, and the holidays, and the Thanksgivings, and Christmases, and sleep, and meals, and lots of time . . . [Obstetrics requires] a giving up. The 24/7 aspect of it, the fact that it is so emotionally demanding, draining, that over the years it has become progressively less rewarding financially. The spiritual part is to feel called enough to keep doing it against the tide.*

[33] Priscilla Stills-Blair [pseudo.], interview by author, audio recording, 29 September 2010.

Despite the difficulties attendant to obstetric practice, obstetrician Anderson said, "I can't imagine doing anything else. There is nothing more satisfying," articulating her work in terms of a vocational calling:

> *I believe that I was put on earth to do this. God has put me on the earth for this. There are times I believe I would rather be doing something else, [but] this is what I was called to do. This is what I'm supposed to do.*

Family medicine physician Patricia Woods similarly described:

> *I feel, or I felt like, I was called to be a doctor . . . I spent years trying to talk myself out of it and was so unable to do so and finally just caved in and went to medical school. . . . It wasn't that, angels descend, burning bushes, any of that, it was just, it became what had to be. I guess I could have ignored it, but it got pretty painful . . . . I think that I was called, and for what purpose, I have no clue, no clue, but I think that I was, and I tried not to listen.*

Like Anderson and Stills-Blair, Watson described the grueling time commitment required by obstetric training and practice and the ways in which it impeded her ability to view herself in a holistic way:

> *MPW: Did your spirituality . . . change as a result of being a physician?*
>
> *A: To be very honest my answer is probably . . . and the reason for that is I've kind of had a religious crisis over the last five years, trying on different hats for what it feels deep inside me, like I actually believe in. I think sometimes it's because, just as a young woman, it feels like all I am is a professional in a service industry and none of what I am is kind of a holistic individual who has balance in her life and gets to have meaningful experiences herself on a daily basis that contribute in some way to a community. I know I contribute to the community by doing this job, but I sometimes feel like I'm too caught in my own version of a rat race and I can't find the beauty in what I do, and I wonder if there's something bigger out there for me, and maybe that's why I need a church to be my community. I don't know. Not maybe because I'm an obstetrician but because training to become a physician has been an eighty-to-a-hundred-hour-a-week process for the last ten years and I kind of lost me in the process. Sadly.*

Like Anderson, James, and Woods, Watson similarly explained her persistence in pursuing an obstetrics practice in terms of a calling. She said:

> *It's been such a voice inside me forever that every other thing that I've tried to do with myself doesn't fit. If I even now try to say this is too much of a rat race, I'm going to be a stay-at-home mom, that doesn't fit. If I try to say well, I'm going to back down and go back and teach high school, that doesn't fit. This is what I should be doing. And I get as much as I can get downtrodden, I get so much positive reinforcement from colleagues, from patients, from how easy it feels like it has come to me. That every step was blessed: that it was just what I was supposed to be doing . . . . Everything happened when it was supposed to happen and I just walked through the next door, because I was supposed to be here right now.*

While a great deal of feminist literature about the field of obstetrics focuses on obstetricians as oppressors of women, there is little scholarship from social sciences and humanities that acknowledges the emotional and spiritual needs of these female obstetrics providers, or suggests reforms that would benefit them and their families.

A necessary first step in securing such reforms is acknowledgement of the limitations on physicians—that they are, as obstetrician Austin Franklin put it, "not God."[34] In the first half of this chapter, I discussed the importance of surrender and acknowledging the out-of-control nature of birth with respect to *patient* spirituality. The recognition of birth as an event in which things beyond control happen is equally critical to *physician* spirituality. Providers expressed this sentiment in two major ways. Perhaps the most obvious expression was the idea that it is important for physicians to acknowledge the things outside of their control so that they maintain humility in their practice. Less obvious, but perhaps equally important, is the idea that recognizing the out-of-control nature of birth allows physicians to avoid an unreasonable burden of guilt when death and disability occur, which they inevitably do over the course of a long obstetric practice.

[34] Austin Franklin [pseudo.], interview by author, audio recording, 25 May 2010.

Obstetrician-gynecologist Priscilla Stills-Blair, a Seventh Day Adventist, talked about the importance of recognizing the out-of-control nature of childbirth in terms of physician humility:

> *I think [spirituality] ought to be [a part of hospital birth]. Childbirth [and] anything surgical where you have risks of things going wrong. I ask Him to use my hands. He's using our hands and our minds to help us make the right decisions, in deciding what course of action, medical course of action a patient is going to have.*
>
> *I think it ought to be. If not, I think a physician would get a big head, to think that it's them. In my opinion it's not. It's through you. You're being used to accomplish these medical miracles. Because things can go wrong any step of the way, for any patient. Things can go wrong. I think that's an important aspect of being a physician is to be as spiritual as well and not allow it to go to your head that you're the one making these things happen because you're not. You're being used as a vessel to take care of patients and do what's right.*

Stills-Blair points out the importance of humility in medical practice so that a physician doesn't "get a big head." But humility in medical practice is critically important beyond simple avoidance of hubris. Doctors and nurses are susceptible to feelings of extreme guilt and anxiety over the patients in their care when something goes wrong. In the course of a typical intern year, an obstetrician-gynecologist might be exposed to more death and disability than the average Westerner will witness over the course of a lifetime. The sheer quantity of experience is compounded by the fact that physicians and nurses bear a very special responsibility toward the people that they watch die. From this perspective, acknowledging that some things in life are beyond medical control can bring great comfort to maternity care providers. Army physician Austin Franklin explains:

> *There are times when it doesn't matter what you do as a doctor, there are bad things that are going to happen to good people. And it's just the nature of life . . . And so for me to be able to get through those times, you can always hope for the best, but you can't always expect the best outcome because you know the statistics, you know that this baby is born at twenty-four weeks, is going to have fifty-fifty chance of survival. And of those babies that survive, ninety percent of*

> *them are going to have severe, lifelong impairments. And so you can hope that they're that fifty percent that are in the positive and that they're in the ten percent that's going to do well, but you know that the vast majority of them are going to have poor outcomes. And you can do everything in your power to try to keep them pregnant, but there are things that are beyond our control. And that's where that whole spirituality [aspect comes into it] . . . For me it's being able to let go because I know I'm not God, I know I'm not all powerful, and I know that these are things that I only have but a limited ability to affect that outcome. And so as long as I am doing the best that I can with the best information that I have, and I'm using all the resources that I have, that I know that I'm doing all humanly possible to help improve their odds. Beyond that, it's destiny, it's God's will. And that gives me some comfort.*

For Franklin, medical care provokes a fundamental question of theodicy. He says, "There are bad things that are going to happen to good people," and realizes that, absent the recognition that some things in obstetric practice are beyond human control, he himself would bear the brunt of responsibility for that grave injustice, that "bad things happen to good people" because of some failure on the part of the physician. The acknowledgement that, "I know I'm not God, I know I'm not all-powerful, and I know that these are things that I only have but a limited ability to affect that outcome" is a great comfort in a practice that inevitably includes suffering, disability and death of patients.

A critique of obstetrics that does not take into account the perspective of obstetric providers is limited. The perspectives of these providers help destabilize the mainstream feminist critique of Western obstetrics in terms of power and control. A paradigm that assumes the birthing woman as the locus of rational decision-making in an active rejection of unnecessary obstetric technology is inadequate to the task of providing a spiritually and emotionally fulfilling birth environment for both patients and providers.

What is required is an understanding of women's empowerment during labor and birth that simultaneously rejects the demeaning, mechanizing and dehumanizing elements of obstetric ritual and at the same time leaves space for the acknowledgement of fear,

anxiety, and loss of control as an important aspect of birth in particular, and women's spirituality in general. An attention to the importance of trust in the therapeutic relationship is essential to the development of a paradigm for maternity care that facilitates spirituality in hospital birth. Finally, the importance of facilitating sustainable, emotionally and spiritually fulfilling practice environments for providers should be one important focus of feminist scholarship in obstetrics.

SECTION III: PATIENT PERSPECTIVES

Chapter 5:

Blurring the Home-Hospital Divide: *Narrative Variations on Birth Technology and Place of Delivery*

Like many of the women I interviewed, Jane Rogers had worked as a maternity-care provider for years before having children of her own. Rogers is a doula and childbirth educator. She teaches a spiritually-focused childbirth class based on Pam England's *Birthing From Within* model. *Birthing from Within* is a philosophy of care that focuses on childbirth as a major life-cycle event, addresses the ritual aspects of contemporary obstetrics directly, and relies heavily on the creative arts as a vital component of childbirth preparation.[1] Like many women in her community and in her childbirth education classes, Rogers appreciates the gentle, low-tech, and personalized environment of home birth. She sometimes uses the phrase *jiffy lube experience,* a term coined by a physician friend of hers, to describe the routinized, high-tech birth experience common in American hospitals. When she went into labor, Rogers had been doing extensive preparation for a home birth for months. But after a labor that was excruciatingly painful and prolonged, she transferred to a hospital. The contrast was intense, particularly in terms of obstetric technology. But when the low-intervention environment of home was replaced by a highly technological hospital experience, she recalls being surprisingly thankful—so much so that Rogers, who was raised Mormon but no longer identifies as religious recalls, "I spoke Jesus' name." She said:

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[1] Pam England and R. Horowitz, "Birthing From Within Holistic Sphere: A Conceptual Model for Childbirth Education," *Journal of Perinatal Education* 9, no. 2 (2000).

> *I felt very very thankful and very lucky to have medical technology. I was never so thankful for an epidural . . . I was so grateful. I spoke Jesus' name.*
>
> *I was never so thankful for the Jiffy Lube experience because it hastened pain relief . . . I saw that Jiffy Lube through the eyes of a mother instead of through the eyes of a birth activist . . . I was able to see all this technology, experience it, and not feel like my birth was defined by it. . . . All I can say is that in the midst of a highly technological birth, lots of tubes and monitoring and everything, I did not feel like I was less than a woman. I did not feel like I was having less of a birth experience.*[2]

Katie Freeman, a middle-class woman in her thirties who is non-religious, and describes her spirituality as, "searching," also began a planned home birth that resulted in a transfer. But Freeman describes her transfer experience quite differently from Rogers. When her eldest daughter, Louise, was born by cesarean section after a transport from a long and painful labor during a planned home birth, Freeman expressed a deep gratitude for the availability of obstetric technology after her transport, but nevertheless described her cesarean birth as a traumatic event that "left some wounds." Freeman described:

> *It felt like I was in a herd of cattle with a little number on my ear. I kept trying to personalize it and I kept trying to connect with people who were dealing with me. It was really hard to make a connection. It left some wounds that had to be healed. And it wasn't so much that I had this big fantasy of having a home birth, I was realistic about it . . . It was more just feeling like a number and a name on a piece of paper. And just assuming that everyone is the same.*[3]

Then there was Meredith Marshall, a young non-denominational Christian woman who set out to deliver in a freestanding birth center using the Bradley method, but wound up with a cesarean section after an excruciatingly painful 40-hour labor she described as "surreal and traumatic." She described:

> *It's kind of a miracle that the medicine was there. At several points at the end I thought, "What if I didn't have the option of the hospital or of the c-section?"*

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[2] Jane Rogers [pseudo.], interview by author, audio recording, 15 June 2010.
[3] Katie Freeman [pseudo.], interview by author, audio recording, 11 May 2010.

> *Had we been in pioneer days, one or both of us probably wouldn't have made it. It was at that point of just sheer exhaustion and misery and pain and . . . you kind of give in to it because you know there's nothing you can do and you're kind of helpless in that way and you're just kind of trusting that it will end [laughs] somehow.*
>
> *Most of the things I try to do . . . they tend to be humbling. I'll set out to do something and I'll not quite get there . . . There's something to not quite making it. . . . I have friends who did it the natural way, and while I think they have every right to be proud of their effort and really encourage people to do that . . . you can also tell that they are really proud of themselves and their accomplishment—they feel like they've conquered the moon, and that they did something [great]. And they did, they did! I don't want to undermine them. But I know for myself if I had had that success maybe it would have gone to my head a little too much and that wouldn't have been helpful . . . In that sense I'm grateful for the humility.*[4]

Like Rogers, Marshall was grateful for the pain relief when it came, as well as the availability of surgery. But unlike Rogers, though Marshall interpreted her experience in an unusually positive light, she still came through her birth with a sense of having failed in some way.

The range of interpretation of obstetric technology, hospital routine, and place of delivery in these birth stories is extreme. Though each of the three women expressed gratitude for the availability of obstetric technology, particularly anesthesia, each interpreted her experience in a drastically different way. Rogers emerged from her transfer without any sense of "having less of a birth experience," whilst both Freeman and Marshall experienced their transfers as traumatic. But while Freeman was traumatized by the highly routinized experience of impersonal clinical care, Marshall's trauma resulted both from an experience of extreme pain during a prolonged and unmedicated labor, and from a sense of failure to give birth in what she described as, "the natural way," that is, vaginally and without anesthesia.

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[4] Meredith Marshall [pseudo.], interview by author, audio recording, 18 March 2010.

How is it that one woman experiences epidural anesthesia as a failure while another embraces it with gratitude? Why would Freeman experience isolation and trauma through obstetric routine while Rogers describes being thankful for the "jiffy lube experience"? How did the Bradley method, a system of childbirth education intended to empower women in birth, result instead in feelings of trauma and failure for Freeman? The contemporary childbirth debates, politically oriented and focused very tightly on issues of obstetric technology and place of delivery, tend to obscure the subtle kinds of distinctions that these women's birth stories evoke.

This chapter focuses on the narrative interviews conducted with 23 women who gave birth in hospitals. It also draws on interviews with maternity care providers to contextualize these birth stories and to expand on some of the themes that emerged. The stories I collected were diverse and moving, and the interpretations of spirituality and religion that women offered were surprisingly varied, even among interviewees from similar religious backgrounds. The overwhelming consensus was that spiritual and religious experiences of birth are possible within a hospital environment given certain favorable conditions. However, these conditions were highly context dependent, and did not necessarily reflect the mainstream criticisms of hospital birth common among home birth advocates.

Narrative is a subtle tool that often works more to complicate than to simplify, but it is nevertheless a vital aspect of understanding birth from the perspective of women themselves. These birth stories both reinforce and destabilize mainstream criticisms of contemporary American obstetric practice. While blunt criticisms of obstetric technology helps define and politicize the alternative birth movement, it leaves little room for experiences like Marshall's where technology is experienced as salvific, or Roger's where routine is helpful. Similarly, the debates about birth space have created intense

polarization over the literal issue of home versus hospital, but obscure the subtle way in which positive birth space can be created and maintained metaphorically within a hospital environment.

This chapter will begin by discussing the role of obstetric intervention in birth, showing how interviewees focused less on the presence of intervention per se, than on the perception of cold and impersonal care. Rather than feeling that the application of obstetric technology was a barrier to spiritually sensitive care, interviewees sometimes described specific technologies as facilitating spiritual experience. However, they were generally critical when they perceived the hospital environment as a barrier to individualized care. Second I will examine place of delivery, perhaps the most polarizing and heated topic in the contemporary childbirth debates. In my interviews, women often described desiring access to hospital care, but simultaneously wanted an environment that felt personal and protected. An expanded concept of birth territory that allows for the idea of sacred space within a hospital can facilitate the perception of a personalized environment on hospital grounds. Finally I will examine a single birth story in detail. Marion Graves Wilder's hospital waterbirth, which took place under the care of a compassionate and empathetic obstetrician, challenges many preconceived notions about the differences between hospital and home birth and suggests the possibility for spiritually sensitive and compassionate, hospital-based maternity care.

BIRTH STORIES

The birth story is a narrative genre that carries a great deal of weight in home-birth communities. Most often told in a colloquial first person voice, birth stories are narratives of individual births, often told in the voices of women who have given birth. Because they suggest the individualized nature of each birth and allow the perspectives of

individual women to come to the forefront, these stories are afforded great respect among many home-birth midwives. With the advent of the internet, the birth story genre is enjoying what might be a heyday among pregnant women and recent mothers. Many of the women I interviewed pointed me to their weblogs, or to online forums on which they had published written versions of their birth stories. Even more said that they had read online birth stories before their births. The recent explosion of birth stories in internet forums parallels an increasing acknowledgement of the importance of these narratives to hospital birth as well as home birth.[5] Birth stories have long carried a great deal of weight among home birth communities, and they are becoming increasingly important for hospital-based maternity care, particularly among patients. Many online birth forums cater to women receiving maternity care in a variety of settings including homes, hospitals, hospital-based and freestanding birth centers.

In home-birth midwifery circles, birth stories are often hailed as sources of authoritative knowledge through embodied experience. These narratives are often included in home-birth midwifery manuals, perhaps most famously in Ina May Gaskin's *Spiritual Midwifery,* in which first-person birth stories from individual women comprise nearly half of the text. By contrast, the relevance of birth stories to obstetric education and practice has yet to be fully explored.

Before analyzing the content of these birth stories, and the interviews that followed, I want to say a few words about the potential importance of birth stories to

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[5] Jane Staton Savage, "Birth Stories: A Way of Knowing in Childbirth Education," *The Journal of Perinatal Education* 10, no. 2 (2001): 3-7; Ruth E. Page, "Evaluation in childbirth narratives told by women and men," *Discourse Studies* 4, no. 1 (February 1, 2002): 99-116; S Ulrich, "First birth stories of student midwives: Keys to professional affective socialization," *Journal of Midwifery and Women's Health* 49, no. 5 (2004): 390-397; Cheryl Tatano Beck, "Pentadic Cartography: Mapping Birth Trauma Narratives," *Qual Health Res* 16, no. 4 (April 1, 2006): 453-466.

medical obstetric education and to patient care, and situate my discussion within the field of narrative medicine. As I have suggested, a great deal of existing literature on birth stories has honed in on home birth populations. Birth stories have not enjoyed the same privileged place, and carry less authoritative weight in discussions of hospital birth, particularly from the physician perspective. These stories are nevertheless critically important to the study of spirituality in birth. Narrative approaches are particularly well suited to the study of religious and spiritual experience because of the importance of metaphoric and symbolic thinking to religion and spirituality.[6]

The interviews described here demonstrate the importance of the birth story to hospital-based maternity care, expanding on the emerging body of literature from nursing and nurse midwifery and emphasizing the critical importance of narrative to an understanding of spirituality in hospital childbirth from the perspective of women who give birth in American hospitals.

OBSTETRIC TECHNOLOGY/OBSTETRIC INTERVENTION[7]

> *"In contrast to the subversive potential that the unreflective and, at times, seemingly masochistic application of technology engenders, I have witnessed time and again how an appropriately and sensitively applied technology can enhance the experience of pregnancy and childbirth for women."*[8]
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> -*Anne Drapkin Lyerly, MD, FACOG,* "Shame, Gender, Birth," *Hypatia,* 2006.

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[6] David Yamane, "Narrative and Religious Experience," *Sociology of Religion* 61, no. 2 (Summer): 171-189.

[7] As might be expected for such a polarized debate, many of the ideas I will refer to have (at least) two different commonly used terms. While home birth advocates often use the term, "obstetric intervention" to describe the way that technology intervenes in the otherwise natural and normal process of birth, obstetricians tend to prefer the more neutral term, "obstetric technology."

[8] Anne Drapkin Lyerly, "Shame, Gender, Birth," *Hypatia* 21, no. 1 (2006): 101-118.

"I had a birth plan that I gave them and they were really receptive. I didn't ask for anything ridiculous. My doula was great. I would put something like, 'Don't deliver the placenta, have it come naturally.'

And my doula would say, 'But what if they have to? They might medically have to deliver your placenta.'

So I thought, "Oh yeah, you're right." I really thought about things like that. Like, "Don't hook me up an IV or something for water."

And she would say, "What if you need that water? We want to go natural but let's think about what if you really need these things? We want to let them be able to do it.'"

-Jennifer Martin

The use or misuse of obstetric technology in contemporary American maternity care defines a major battleground for the American home birth movement. Activism surrounding birth often focuses on what are termed, "obstetric interventions," applications of obstetric technology ranging from IV hydration in labor, all the way to surgical delivery via cesarean section. Home birth advocates point to the greatly increased number of obstetric interventions employed in hospital birth versus home or birth-center birth, and many doulas see mediating between client and hospital to help limit the use of obstetric technologies as a part of their job. Obstetric technology is a central focus in contemporary childbirth debates in a polarizing way. On one side, advocates of hospital birth sometimes assume that more access to, or even more use of, obstetric technology is necessarily safer and leads to better birth outcomes. Patients (and sometimes physicians) tend to equate technology with science, progress, and modernity. This helps explain the ubiquity of technological interventions that do not improve

morbidity or mortality.[9] To quote a labor and delivery nurse I interviewed who was critical of the midwife-staffed birth center in which she worked, high-tech birth is sometimes seen as "the 2000's way of doing things." The overuse of technology in the hospital leads to a culture among birth activists that tends to view most technological intervention negatively. Stevie Shalwater, for example, a young mother of two who had her first baby in the hospital with doula support described the importance of her doula in helping to limit the amount of intervention in her birth, saying:

> *We got a doula because we read about how helpful they are with women. Not only emotionally: they interact with the doctors when you can't really do that. When you're in labor land and can't really say, "No, I don't want the epidural," or "let's hold off on whatever they want to give me, the IV or whatever."*[10]

While advocates of hospital birth can be vitriolic in their advocacy for obstetric technology, equally polarizing attitudes exist among home-birth activists who sometimes assume that obstetric technology, though sometimes necessary, is generally a dehumanizing, disempowering tool of patriarchal control.

Anthropologists have referred to the drive to maximize the use of medical technology where it is available as, "the technological imperative." This refers to the idea that if a technology can be used, it should. An opposing stance, where technological intervention is generally seen as harmful, is less commonly discussed among social scientists, but is a common source of tension between obstetricians and their patients. Army physician Austin Franklin explains:

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[9] One high-profile example is continuous electronic fetal monitoring, an extremely common intervention which has been shown in multiple well-designed studies to increase rates of operative delivery without improving neonatal outcomes. Ernest Graham et al., "Intrapartum Electronic Fetal Heart Rate Monitoring and the Prevention of Perinatal Brain Injury," *Obstetrics and Gynecology* 108, no. 3 Pt 1 (September 2006): 656-666.

[10] Stevie Shalwater [pseudo.], interview by author, audio recording, 18 March 2010.

> *A lot of times people in general think more medial influence on their delivery is bad. I caution people to say, "Hey, a hundred years ago when you had less medical knowledge and less medical intervention ten percent of women died in childbirth. And that's not true today. Now women dying in childbirth is a rarity, a very, very rare occurrence. And that's because of the medical influence you have on their obstetric care and their delivery." And so sometimes [there is a misconception]—people are so worried about their having an IV or getting an epidural or any of the other hundred things that might happen to them from admission to delivery—that they think, "Oh, if I didn't do those things then I'm going to have a better outcome." And that's typically not true.*[11]

Franklin makes a common argument that the decrease in maternal and infant mortality in the last century has been mainly a result of hospitalization of birth. This premise is widely debated. Still, most maternity-care providers, both midwives and obstetricians, agree that access to emergency obstetric care is a positive good and that in some high-risk cases, hospitalization and intervention during birth is necessary to prevent morbidity and mortality.

With respect to providing spiritually humane care, the polarizing debates about obstetric technology can have damaging repercussions for patients and providers. The emphasis on spirituality that attends much of the home birth literature tends to focus on technology as a force working against the achievement of a spiritually fulfilling birth. But the assumption that spirituality and medical technology are necessarily at odds is problematic. Especially in the context of an embodied feminine experience like birth, women's spirituality is often entangled with pain, risk, and even death. This uneasy connection is heightened in high-risk pregnancies, which tend to necessitate the most technological intervention and tend to involve the application of medical technologies deemed appropriate by most parties. Ironically these high-tech pregnancies often demand more spiritual care than the average delivery, though there is little discussion of the idea

[11] Austin Franklin [pseudo.], interview by author, audio recording, 25 May 2010.

that birth with a large amount of obstetric intervention can be perceived as spiritually meaningful at all.[12] Jane Rogers, the doula whose birth story began this chapter, suggested the importance for recognition of birth as a spiritual event might be enhanced in cases of extreme technological intervention. She said:

> *Once you have a baby you . . . are completely transformed. We are lacking forms to celebrate what that woman did to get that baby out. And for some women it is truly epic. Especially with all the technology. It can be truly epic what she endures. Her physical body, and spiritual body, and emotional body, and the baby.*

Rogers often evoked the hero's quest in her discussions of spirituality and birth, and she hints at that mythic narrative structure in this excerpt with her repeated use of the word *epic*. In a fascinating reversal of most contemporary arguments about spirituality and birth, Rogers frames the encounter with technological intervention not as a barrier to spiritually relevant birth, but as the defining aspect of a hero's quest. In her formulation, it is, "all the technology . . . she endures," that makes the birth "truly epic."

Though she does not address spirituality directly, obstetrician Anne Drapkin Lyerly has made the argument that obstetric technology, when sensitively applied, can enhance a woman's experience of birth rather than necessarily detracting from it. She writes that characterizing medical technology as the major barrier to a fulfilling birth, "mischaracterizes the source of women's discontent, and, in doing so, risks further disenfranchisement of the birthing woman."[13] Lyerly is an obstetrician/gynecologist with a background in women's health and bioethics. In keeping with most major voices from the anthropology and sociology of childbirth, Lyerly argues that childbirth is, "not simply

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[12] Glenn Breen, Sheri Price, and Margaret Lake, "Spirituality and High-Risk Pregnancy: Another Aspect of Patient Care," *Association of Women's Health, Obstetric and Neonatal Nurses* 10, no. 6 (Dec-2007 undefined): 466-473; Sheri Price et al., "The Spiritual Experience of High-Risk Pregnancy," *Journal of Obstetric, Gynecologic, and Neonatal Nursing* 36, no. 1 (February 2007): 63-70.

[13] Lyerly, "Shame, Gender, Birth," 102.

a biological or even a 'natural' event, but rather an event with profound bodily and existential meaning."[14] She further argues that a focus on the presence or absence of obstetric technology is inappropriate, suggesting that the sensitive application of some technologies can enhance the experience of birth for women and their families. Rather than technology per se, Lyerly suggests that any practice, technological or otherwise, that reinforces female shame, will detract from a fulfilling birth experience.

Lyerly's insights are applicable to a discussion of the impact of technology on acknowledgement and facilitation of spiritual experience in childbirth. As Rogers' description of her positive "jiffy lube" experience suggests, not every woman believes that obstetric intervention, what Lyerly has called the "sensitive application of obstetric technology," necessarily precludes an experience of childbirth as spiritually or religiously significant.

Furthermore, in some instances women described obstetric technologies as *sources* of religious or spiritual experience during pregnancy and birth. Jennifer Martin's birth story is an excellent example of this phenomenon. Martin is a young, evangelical Christian who experienced a contentious obstetric technology, transvaginal ultrasound, as a source of, rather than a barrier to, spiritual experience. Martin, who had a threatened miscarriage in her first pregnancy, described the presence of a heartbeat on the ultrasound monitor as "God promising me [my baby's life]."

Lyerly mentions prenatal ultrasound specifically as an example of a potentially empowering obstetric technology. She points to the many moments in her practice where she has witnessed the usefulness of ultrasound in reinforcing the relationship between mother and fetus. Building on Lyerly's analysis from the perspective of spiritual and

[14] Ibid., 101.

religious experiences of birth, Jennifer Martin's story illustrates the potential for interpreting ultrasound as a religious experience.

Martin described events in each of her two pregnancies where she felt God was reassuring her about both her ability to parent, and the safety of her children. The first experience takes the form of a fairly traditional religious narrative in which a relative feels that God has a specific message and relays it. Martin has generalized anxiety disorder and had vaginal bleeding during both of her pregnancies. With her second pregnancy, she describes having an experience where her brother in law called to tell her the baby would be healthy: "It was almost like a prophecy," she described:

> *[He said:] "God wants you to know that, you're a wonderful mother, that the second child is just going to bring you into a better place with that, and He's really proud of you." These are all things that I had been doubting. "The other thing is, is that baby in your womb is safe and secure and is going to be born healthy." And that was it! From that day till her birth I never had one ounce of anxiety. That, for me, was like God confirming her life.*[15]

In addition to this traditional religious narrative, Martin also described a religious experience during her first pregnancy that occurred through the fairly invasive obstetric technology, transvaginal ultrasound. "We think we miscarried a twin with Jack," she explained:

> *On our drive down from Brooklyn to Austin, when we were in Pennsylvania, I went to the bathroom and I wiped and there was a lot of blood. And I [thought], "Oh my God." And we went to the emergency room and it was one of those situations: we were there forever. I was too early on for them to tell really anything. One nurse told me I probably miscarried, another one said maybe. I had three different people telling me three different things and it was all pretty much, you'll just have to wait and see.*
>
> *So after that — this is all really traumatic for us, you know — we were at a truck stop and I went to the bathroom and passed this—nothing that looks like it's*

[15] Jennifer Martin [pseudo.], interview by author, audio recording, 22 March 2010.

meant to come out of your body. It was like a little sac. And I screamed and called for my mother-in-law because I couldn't look at it. And she actually pulled it out of the toilet with some toilet paper to look at it and she said, "I don't know what that is but I don't . . . I don't think it's good." And I continued to bleed and I was crying as we're driving home, convinced we lost the baby.

So literally with our moving van we drive right into our doctor's appointment— our whole little caravan in the parking lot. And I go up and it was so weird because I didn't even think I wanted to be pregnant. We definitely don't believe in abortion or anything, so I was just kind of adjusting to the fact that we were going to have a baby and getting excited about it, and then here I am losing it. And it's just a weird feeling to lose something you only had so quickly but you know what it could've been. It's really sad. We were sitting in the office and the doctor was really sweet and just talked to us a little bit about what would happen, like the D and C and then we can try [to get pregnant] again right away. And I was just bawling; I was so sad. But then she did a sonogram vaginally — obviously they can't see on top of your belly yet — and she saw a heartbeat. And we were ecstatic and confused.

Transvaginal ultrasound is a procedure performed when the fetus is too small to be seen by an ultrasound machine placed on the abdomen. Because visualization of the contents of the uterus is easier through the thinner walls of the vagina, a long ultrasound probe is inserted vaginally. Ultrasound has been the focus of a great deal of feminist discourse, often in the form of criticizing the technology for its apparent alienation of women from their bodies by projecting an image of the fetus onto a screen and into the popular imagination. Transvaginal ultrasound adds the additionally disconcerting and potentially violating element of a vaginal probe. But far from experiencing alienation, for Martin, despite this invasive and potentially violating technology, "seeing that heartbeat on the monitor," was the means by which God personally delivered a promise of safety. She expanded:

With both my children, with that situation with my daughter and then feeling like I miscarried Jack and then seeing that heartbeat on the monitor . . . I feel like both of those times were not just promising me healthy pregnancies but God promising me their lives. I really feel like that's a promise that he's made to me from both of those. Here: I'm going to show you; I'm going to give you something tangible . . .

> *I'm going to show you my hand. This isn't just your body making a baby. I'm going to promise you your children's lives. They're going to be fine.*
>
> *I have generalized anxiety disorder so it was really important to me that those things happened. I'm sometimes in periods where I'm on medicine for it, so those were huge for me, really significant.*

Martin's story points to the discord that sometimes occurs between theoretical feminist criticisms of American birth practices and the experiences of pregnant women.

Ultrasound is a particularly contentious practice in feminist critiques of childbirth technology. First of all, ultrasound has been a key player in the abortion debates, both in the recent laws forcing women who desire elective termination to view the image of their fetus on screen before procuring abortions, and from a broader perspective in the way that images of the fetus have been used for political purposes.[16] Coercive transvaginal ultrasound has even been characterized as rape in the context of abortion legislation recently passed in Texas, where State Representative Carol Alvarado made a powerful rhetorical point by waving a vaginal ultrasound probe on the house floor.

Outside the context of abortion, ultrasound has been criticized as an anti-feminist technology that puts the fetus, rather than the woman, at the center of birth, and alienates the woman from the physical experience of her pregnancy.[17] More specifically, ultrasound has replaced quickening, the first time a mother can feel her baby move in the womb, as the defining moment in pregnancy where the baby becomes a central figure.[18] Quickening is a subjective, woman-centered experience that historically defined the moment when a baby's soul entered its body. In stark contrast, ultrasound is an objective,

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[16] Carol Stabile et al., "Shooting the Mother: Fetal Photography and the Politics of Disappearance," in *The Visible Woman: Imaging Technologies, Gender, and Science*, 1993, 179-179.
[17] Wendy Simonds and Barbara Rothman, *Laboring on: Birth in Transition in the United States* (New York, NY: Routledge, 2007).
[18] Judith Lumley, "Through a Glass Darkly: Ultrasound and Prenatal Bonding," *Birth* 17, no. 4 (1990): 214-217.

technologically centered experience. Critics have argued that, by devaluing the woman's physical and internal experience of her baby, ultrasound has alienated her from her body. Scholars also argue that ultrasound has endowed the fetus with the inappropriately elevated status of an independent person and potential rights-bearer whose interests may conflict with those of the mother.[19]

Despite the strength of this critique theoretically, in practice many women find the first moment they hear their baby's heartbeat, or see her image, a very positive and even spiritually charged experience. In Martin's example, far from being a barrier to spiritual experience during pregnancy, she experienced the visual effects of ultrasound ("seeing that heartbeat on the monitor") as God, "showing his hand." "Here," she says, "I'm going to *show* you." This narrative evinces a fascinating reversal of the traditional reading of visual obstetric technology, which suggests that women are alienated from spiritual experience by a picture of the fetus that appears outside their bodies. Instead Martin perceived the image as "something tangible," through which she experienced a promise of covenant fidelity.

In addition to the idea that technology can function as a conduit for spiritual experience, the birth stories I collected also evinced how, in its more extreme forms, resistance to technological intervention can lead to spiritually negating birth experiences. As Lyerly suggests, an excessive focus on obstetric technology per se can miss the point, and even result in psychological harm to birthing women. She writes:

> Although well intentioned, *analyses that focus on models of birthing rather than women's emotional lives* fail to capture the substance of the insult that women have recently incurred in giving birth. In holding technology culpable, these analyses are not only inaccurate but also threaten to disenfranchise women for

[19] Stabile et al., "Shooting the mother."

> whom sensitively applied medical practices can enhance both the safety and agency so important to a good birth.[20]

Lyerly criticizes, in particular, situations where natural birth is so idealized that patients perceive technological interventions as a personal failure, as in the example of Jennifer Martin.

Three of the doulas I spoke with, Jane Rogers, Rachel Marini, and Renee Miller each emphasized several times that the expectations of what should happen in a birth can cause trauma to a laboring woman, since birth is rarely predictable. In particular, because of the centrality of obstetric technology in the contemporary childbirth debates, fear and mistrust of obstetric technology is common among women oriented towards undedicated childbirth. Miller, a prenatal and childbirth doula, told the following narrative of "one of the worst births I ever attended," which highlights the spiritually negating possibilities of being rigidly opposed to obstetric intervention:[21]

> *One of the worst births I ever attended ended in a C-section and that's not why it was awful. It was awful because this woman's partner left on three different occasions. Because his mother was a homeopathic doctor, he was really against any kind of medical hospital intervention. But she [his partner] had all kinds of high-risk things that landed her in a hospital with an OB instead of midwife and not in a birth center.*
>
> *She ended up having an epidural and a C-section and her baby was this transverse lie baby that was two weeks overdue and there was mec [meconium] everywhere.*[22] *But he was really upset every time someone suggested anything*

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[20] Lyerly, "Shame, Gender, Birth," 116-117.

[21] Renee Miller [pseudo.], interview by author, audio recording, 4 May 2010.

[22] In a transverse lie, the baby's spine is perpendicular to that of the mother's. This means that, rather than presenting head first, as the vast majority of babies do, a shoulder enters the birth canal first. Once the shoulder is lodged in place, the baby's head cannot deliver, and labor cannot progress. Very small babies can sometimes deliver in this position, albeit often with damage to their abdominal organs, by doubling over, and if a baby is found to be transverse early in pregnancy, she can often turn head down on her own, or be a candidate for an external version. But if a baby is still in this position at a term delivery, without cesarean section a transverse lie usually results in stillbirth, the eventual rupture of the uterus, and often maternal death as well. Untreated transverse lie is a true obstetric emergency nearly inevitably requiring cesarean delivery: Early obstetric practices for untreated transverse lie involved destruction of the fetus

else. It was just rough. And so he left a couple of times, was unreachable . . . He wasn't there for her epidural. . . . She ended up having an emergency C-section.

So they're wheeling her down the hall and he's not here, and he's coming in, he ends up coming back to the hospital right as they're wheeling her into the operating room. And the nurse had handed me a stack of scrubs because there was nobody else there and I was going to have to go with her and I was going to have to follow their baby to the NICU. And he just looked at me and he says, "How dare you let this happen?" He was so emotional and he was so wounded, and he thought that everything that they had wanted . . . That we had shoved down all of this medical ritual down their throats, which really was not how it had happened, but he was so upset he couldn't stay for the whole thing.

Even if we bracket issues of safety during this birth, the father's unwillingness or inability to adapt to an inevitable technological intervention in labor came at a great emotional cost. Rather than facilitating an experience of birth as spiritual, in this birth story a rigid belief that characterized all obstetric intervention as unnecessary led to alienation of the father from his partner and baby during the birth.

This birth story also illustrates the flexibility needed in the role of a doula. Rather than trying to prevent an unnecessary intervention from occurring, which is a stereotypical function for a doula; Miller is put in a position where her job is to convince the father to participate more fully in a highly technological birth where obstetric

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through the vagina and its subsequent removal in parts. The cesarean section in this birth story is almost certainly medically indicated. For an obstetrics perspective on transverse lie, see Ronald Gibbs, David Danforth, Beth Karlan, and Arthur Haney, *Danforth's Obstetrics and Gynecology, 10th ed.* (Philadelphia, PA: Lippincott, Williams and Wilkins, 2008) 411-412. The grandmother of the American midwifery movement, Ina May Gaskin writes similarly, "The transverse lie baby cannot be delivered naturally unless it can be turned." Gaskin, *Spiritual Midwifery, 4th ed.* (Summerton, TN: Book Publishing Company, 2002) 320. Furthermore, once membranes are ruptured, as was the case in this birth, turning the baby is contraindicated since the risk of uterine rupture is high. Meconium, a baby's first stool is passed in utero in 20% of pregnancies. With thick meconium stained amniotic fluid, there is a risk that the baby will inhale a combination of meconium and amniotic fluid and develop a dangerous respiratory complication called meconium aspiration syndrome. The risk of meconium aspiration increases with time after the due date. The fact that this baby was still in a transverse lie at two weeks past term coupled with Miller's description of "mec everywhere" likely indicates that the parents were extremely resistant to any kind of obstetric intervention even in the face of very appropriate medical advice to the contrary.

technology is patently necessary. She did so in a rather unorthodox, but ultimately successful way:

> *This is the one time I've ever yelled at a client. I said, "You put on the fucking scrubs, take the fucking camera, and get in the fucking OR. Your wife and your baby daughter are going to ask you where you were on this night and you're going to say, 'I was out in the parking lot sulking.' And that's unacceptable to me, and you're really going to regret that as a father, so get in there!"*
>
> *And I threw his little cap on him and helped him into his scrubs and shoved him in the room and ten minutes later he walks out with this little baby and they're on their way to NICU, and he's saying, "It was so wonderful, my baby's so beautiful, thank you so much for being so . . . " [He was] just in love with his wife and with his baby. And I did not feel the need in my postpartum visits with them to bring up the fact that he was an asshole through the whole thing. It was like, "I'm so glad that you had a good experience, I'm so glad that you love your baby," and kind of try to help them have a better memory of the day. But it's hard. So I think a doula's role is really to try to help however she can, and sometimes it looks like that really awful experience, you kind of have to step in and be somebody's total support.*

In this narrative, Miller helps facilitate a positive emotional experience by forcefully insisting that the father accept technological intervention.

Similarly, as Lyerly describes, the sensitive application of obstetric technology can contribute to an empowering birth experience. Stevie Shalwater, who originally hired a doula partially to help decrease the possibility of obstetric intervention, describes the importance of her doula's role in eventual helping her decide to have epidural anesthesia. Shalwater's birth is an example of a time where a stigmatized intervention, epidural anesthesia, contributed to an empowering birth outcome, vaginal delivery. She explained:

> *I do tell people if I think I would have had a C-section if I didn't have a doula because my labor was thirty-two hours long total, I think, and started with my water breaking . . . . We got to the hospital and I think I was only, I don't remember how many centimeters, it was like six, not as much as I wanted to be. I was like, "No!" And that's where the doula came in, to encourage me, "You can do this, it's okay." And so she had me walking, I didn't lay in the bed and have*

> *the doctors tell me what to do. It's also kind of freeing to have her there and think, "Okay, I'm allowed to do this."*
>
> *So it was about twenty-four hours into it and I still wasn't ten centimeters. I was almost there. I don't remember, like eight or nine, really close, but exhausted. So they wanted to give me an epidural. We talked with the doula and decided that was a good decision because I just had no energy left. If I didn't get the epidural I don't think I would've been able to push. I just didn't have it in me. So I got the epidural and slept basically for a few hours and then I woke up and he [the doctor] says, "You're ready." And I pushed for three hours and forty-five minutes after that. It was a long, long labor. But I did it! So it was very empowering. Even though I didn't want an epidural it was still . . . it wasn't a big deal. I just got it. I didn't want the C-section so I didn't get that.*

Rather than obstetric technology per se, it was the feeling of being treated without individualized care that tended to make women feel disempowered in birth.

Shalwater emphasized the importance of avoiding the perpetuation of female shame by suggesting that accepting obstetric intervention is a failure on the part of a birthing woman. She said:

> *I think there is a little bit of [shame] among women that really want to go natural and for some reason it just didn't happen. It makes me [sad], because some of my friends say, "Oh, I couldn't do it." But you did do it! You have the baby. So what if you had to have a C-section or an epidural. That's not a failure on your part; it's just how your body did it.*

Obstetric technology can and should be used to facilitate positive birth experiences for women. But just as technological intervention can be perceived as disempowering and spiritually negating, a rigid attachment to avoiding technology can result in feelings of shame and failure.

It's Not "Just a Job": Perceptions of Individualized vs. Routinized Care

A major theme that emerged was the way hospital care tended to routinize birth. Providers and patients alike repeatedly emphasized the importance of treating patients as individuals and providing personalized care that honored the significance of birth in the

life cycle. When I asked Katie Freeman how health care workers could facilitate spiritual and religious aspects of maternity care in the hospital environment, her response emphasized individualized care. "Everyone has a unique story," she emphasized, contrasting the highly individualized nature of narrative with the homogenizing hospital environment.

> *Honoring people's difference. And actually making people feel comfortable. Being more open. I think its part of my spiritual practice, just trying to be understanding about people's differences. Everyone you meet, whether it's Margaret, or me, or that guy who owns the coffee shop. Everyone has a unique story. And if you talk to them you'll probably get a little piece of what makes them who they are. And they're probably not as simple as you thought they were, or as stupid or unfashionable, or whatever it is that you think. Just taking away that judgment and just having an open heart. . . . I don't know if they can ever teach a class on that in medical school or nursing school. I don't know what they can do to make everyone feel this is a special time.*[23]

Freeman also empathized with the emotional strains placed on maternity care providers suggesting, "Maybe having more time off, different hours," might help providers be more attentive to the spiritual and religious needs of their patients.

Christine Chandler Miller, a non-denominational Christian in her mid-twenties, had a beautiful, doula attended hospital birth without epidural anesthesia. She described the hospital environment similarly as having an energy of "wanting to just get through . . . with birth."

> *I feel like there's an energy in the hospital of wanting to just get through, at least with birth. [Birth is] not an in and out kind of thing. I think [it would help] for doctors and nurses to be more cognizant and remember that this is a huge experience for people, [for] every individual that goes in. And remember that for them[physicians] it's a routine thing. I don't know how they could get to that place, get to a place where they are more aware that this is a huge moment for this person. And so if they want certain music or whatever, if there are prayers or*

[23] Katie Freeman [pseudo.], interview by author, audio recording, 11 May 2010.

> *if they want to put scripture on the wall—like I know a girl that wanted scripture—and I think they let you do that. But just a feeling of acceptance and wanting to feel like they were willing to work with you. I remember wanting that with my doctor. I wanted to feel like she wanted to work with my doula, and [I remember] wanting to feel like she wanted to be a part of my journey.*[24]

Miller compared the work of a hospital to her job as a kindergarten teacher. Like many interviewees, both patients and providers, Miller pointed to the importance of viewing maternity care as something other than "just a job." She emphasized the uniqueness of each patient, saying:

> *It's hard because they have however many [patients]. It's a job for them. I was a kindergarten teacher and if I treated it as just a job I wouldn't have been there with those individuals when they came in that day and didn't eat breakfast. If I just treated it like a job, I would treat this one just like I treat that one. Well this one didn't have breakfast; I have to treat this one a little different because he didn't eat so he's crabby, and if I don't have food to give him he has to wait till lunch. And so maybe I'll let him lay on the floor a little while because his mom and dad for whatever reason aren't able to give what the other kid received. And so I might expect more of the other kid. And so if maybe doctors and nurses could have a little bit of that reminder that I might have to treat this one different because this one's Muslim or this one's Christian.*

Shalwater similarly described the importance of feeling like an individual in terms Suggesting that a good provider works at "making you feel like they're there for you and it's not just their job." She explained:

> *I think my doctor did a little bit of that as much as she could because I feel like they're pressured . . . I couldn't really spend time. But my doctor did a good job of just making me feel I was the only patient and that she cared about my concerns. It wasn't like, "Oh her, this again." Just letting the patients know they genuinely care and their expressions aren't stupid. My doctor didn't make me feel that way, by the way; I would've changed doctors [if she had]. Just making you feel like they're there for you and it's not just their job and they're going through the motions. Maybe the nurses could do that, too. Because a lot of times the nurses are—at least for me, that weren't that bad with me. I've heard people say this*

[24] Christine Chandler Miller [pseudo.], interview by author, audio recording, 22 March 2010.

nurse is not very friendly, they're just coming, they're not very personable, they're not very caring.

Shalwater as well, suggested that viewing maternity care primarily as a job interfered with the ability of providers to think about spiritual aspects of care:

With any job, a lot of times you probably don't think about your spiritual life mix in your job. Like a lot of people get caught up in work, work, work and getting stuff done as fast as possible and that kind of thing.

She further suggested that the major difference between midwives and obstetricians is related to the way they see the profession:

SS: That might be a difference between a midwife and a doctor: The [midwives] y look at their job as . . . Well, they might not use the word holy but they just think it's just an amazing thing for a woman to have a baby, be pregnant, go through birth. It just seems like even though they do a lot of labors they're just more in the moment maybe.

MPW: Why do you think that is?

SS: . . . To me they just seem more caring, like, "I'm here for you and let's do this. You can do this!" Doctors are a little more uptight and job-oriented, like," This is my job." But midwives [think], "I do this because I have a passion for women and birth and babies in a different way."

Barbara Rothman reported on a similar perceived dichotomy between midwives and physicians in her book *Laboring On*. She suggests that midwives generally feel called to attend births, whereas obstetricians tend to have more practical reasons for choosing their specialty. But despite the midwife/physician dichotomy that Rothman and Shalwater pose, the physicians as well as the midwives I interviewed emphasized the importance of seeing each delivery as unique. Obstetrician Melanie Saunders said:

People ask me, 'Why don't you count them?' I'm sure I've delivered between five and seven thousand patients and I've kind of guestimated. But every one is different, I mean every single one. They're just always different. They are never

the same. I'm sure you've heard that over and over again. There's nothing routine about it.[25]

Family physician Patricia Woods described the first delivery she witnessed as a lesson in the importance of personalized care.

> *I was a freshman medical student and . . . they'd hooked me up with this obstetrician here in town who'd been in private practice. He'd probably delivered a bazillion babies. I was so excited. I went with him and I was in his office and then he got called to the hospital for a delivery so I went with him. And I didn't know how to put on scrubs, I didn't know how to do anything. And I watched him. This baby just was born, he handed it off to the nurses, he sewed her up, and left. And that was just it. I was so absolutely amazed at how it was just an everyday thing for him, and for me to witness. And I thought at the time that I'd never want it to be an everyday thing for me. And over the years it's become more every day because it's more routine. But I don't want it to ever be just a shave, shower, put on your deodorant, deliver a baby, go to clinic. I don't want that to be how I feel about it because it means so much more.*[26]

Woods identifies the importance of viewing birth as an, "everyday" experience, but also admits that over the course of a career, routine influences her attitudes.

Next we will look at the way issues of place of delivery are complicated by the narratives of individual women. Though the literal space of home versus hospital is at the center of the contemporary birth debates, providers and patients working within a hospital setting often evoke a more metaphorical idea of what one doula called, "protected space" for birth within the confines of a hospital environment.

BIRTH TERRITORY/PLACE OF DELIVERY

> *"People are seeking a less clinical and more holistic environment. One that acknowledges the connection between mind, body and spirit."*
>
> *– Mary Breton, CNM*

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[25] Melanie Saunders [pseudo.], interview by author, audio recording, 30 August 2010.
[26] Patricia Woods [pseudo.], interview by author, audio recording, 25 March 2010.

Because some of my initial interviewees were women from a community where home birth was encouraged, many of the women I interviewed were familiar with home birth, knew other women who had home births, or had considered or attempted home birth themselves. Speaking with these women underscored the importance of access to spiritually supportive hospital-based maternity care: even in a community where home birth is accepted and supported, many women still desire (or medically need) hospital birth. Particularly for a first birth, many women expressed a desire for the security and access to the technology available in a hospital setting at the same time that they articulated the importance of birth as a spiritual and religious event. Problematically, hospital environments tend to routinize childbirth in a way that obscures its spiritual and religious potential. Julia Pearson, a lawyer in her mid-thirties, who was raised Catholic, summarized this sentiment in the reticent email she sent me in response to my query for an interview. She wrote:

> *I guess we could talk, but I don't know how much help I would be as I don't know exactly if I would necessarily categorize my experience as "spiritual" . . . albeit it was definitely a miracle and every hospital-ish thing detracted from that.*[27]

Katie Freeman echoed Pearson's statement that birth is "a miracle," but that, "every hospital-ish thing" was a barrier to an experience of birth as spiritual. She described the hospital environment as, "negating of spiritual tendencies," saying of physicians:

> *The environment that they have to work in is such a, kind of, cattle mentality, obviously that's got to spill over into how they treat other people. The cafeteria, and everything just being lined up; and you see the woman that's working there stocking it, and the cash register, and the person that's working there, and all the sea of tables and they're all the same, and the lighting, fluorescent lighting, and it's just gross. [laughs] By design, hospitals are so negating of spiritual tendencies. It's just not conducive to that [spiritual experience].*

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[27] Julia Pearson [pseudo.], email correspondence with author, 4 August 2010.

> *When you go into the little chapel, it's different: you know what I mean? Even if you pass by it there's just the quietness and I keep saying the word energy, but I really believe in it. I just think it's there.*

Freeman's statement, contrasting the "energy" of the small hospital chapel with the fluorescent lit hospital cafeteria, is somewhat condemning of the possibilities for spiritually fulfilling birth experiences in such a homogenizing environment.

This would appear to leave women like Christine Chandler Miller, an evangelical Christian in her early twenties who expressed both a desire for the security of a hospital *and* a religiously oriented birth, in a quandary. On the one hand she desired a birth that would honor its sacred elements. At the same time, she valued the hospital's access to "modern medicine." Since the hospital is, to many people, an environment "negating of spiritual tendencies," women who wish to give birth in-hospital must find a way to create a microenvironment within the hospital that facilitates spiritual experience. Midwives and doulas sometimes refer to this idea using the word, "space," as in "the couple needs to have their own protected space." Miller too emphasized the importance of having "space":

> *With our first we felt like it was such a special, sacred [time]. If something went wrong . . . we wanted to be able to have modern medicine to help us, but at the same time we really valued having our own space and having it without medication. And so we felt like getting a doula would really help us.*

Miller characterizes her first birth as not only "special" but also uses the more religiously laden term "sacred." And though she described access to modern medicine, as a priority, she also emphasized the value of "having our own space." Miller's prioritization of "our own space," is common and is discussed in midwifery literature using the concept of "birth territory."

Birth territory is a term, common in home birth literature that examines place of delivery in the context of networks of power. The fundamental concept is that birth takes

place, not just in a literal space, but also on someone's territory. Births that take place in hospitals occur on hospital territory where medical professionals set the rules and norms of behavior. This means that, though patients almost always have the right to refuse unwanted interventions, medical professionals still have significant power and control over which interventions will take place. This varies substantially from home birth, where the birth takes place, not just literally in a woman's home, but also, from a perspective of power and control, on her territory.

The concept of birth territory began with home birth advocates suggesting that, because the hospital environment enforced gender norms of docility and submission on birthing women, home birth, or at least a birth center, was a preferable space in which to give birth. Long utilized mainly as an argument in favor of home birth, where the locus of control shifts toward the birthing woman, theory about birth territory has more recently been expanded for use in a hospital environment.[28] More specifically, Kathleen Fahy and Carolyn Hastie have introduced the idea of "midwifery guardianship" of birth territory, tying the idea of guardianship closely with ideas of midwifery as a spiritual practice. In contrast to the idea that birth in the hospital precludes the possibility for an individualized sacred space, Fahy and Hastie suggest that the midwife can act as a guardian of sacred space in the birthing room, even in a hospital environment.[29]

By tying the idea of birth territory to midwifery guardianship, Fahy and Hastie move beyond ideas of power and control in birth that dominates much of the discourse from the 1970's and 80's to include the importance of women's spirituality in birth. This

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[28] Kathleen Fahy and Jenny Anne Parratt, "Birth Territory: A Theory for Midwifery Practice," *Women and Birth* 19, no. 2 (2006): 45-50.

[29] Kathleen Fahy, Maralyn Foureur, and Carolyn Hastie, *Birth Territory and Midwifery Guardianship: Theory for Practice, Education and Research*, Books for Midwives (Edinburgh: Elsevier, 2008).

useful concept moves the argument away from the literal space of hospital versus home, and focuses instead on protected space as a metaphor for patient comfort, security, and openness to interpretation of birth as a spiritual, religious, or life cycle event. They write, "The midwife guardian . . . creates and maintains spiritually and emotionally safe birth spaces."[30]

Protecting sacred space can also be one of the functions of a doula. For Miller, the presence of a doula helped achieve a space where she felt extremely comfortable, but could still access hospital technology if it became desirable. Doula Rachel Marini echoed Miller's sentiment that protecting space is vital to honoring spirituality in birth. She said:

> *I do think having spirituality present at a birth in the hospital is doable, but you really have to set aside that [space], acknowledge it and go for it and also get really good support. And also stay out of the hospital as long as you can (laughs) . . . I think that having doula support is also really important . . . their main job is to hold that space for the family so that it doesn't get forgotten. I worked in a hospital setting, I know it is really easy to get kind of jaded and forget. There's a routine and a protocol . . . everybody's treated the same, so there isn't as much room for that individual experience and I think that's where the spirituality part of it gets lost.*

CNM Barbara Stanford echoed these sentiments suggesting that "protecting that space" is a major way that maternity care providers can help facilitate religious or spiritual expression in birth. She said:

> *The bigger picture is does the couple feel like their space is being respected, because that will allow for those things to occur. If they feel secondary to the event they're not probably going to say, "Can we stop and have a prayer here?" Protecting that space is very important.*[31]

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[30] Kathleen Fahy and Carolyn Hastie, "Midwifery Guardianship: Reclaiming the Sacred in Birth," in *Birth Territory and Midwifery Guardianship: Theory for Practice, Education, and Research*, ed. Kathleen Fahy, Maralyn Foureur, and Carolyn Hastie (Edinburgh ;;New York: Books for Midwives, 2008), 21.
[31] Barbara Stanford [pseudo.], interview by author, audio recording, 25 July 2010.

When Miller recounted her birth story, the degree to which she felt comfortable and at ease in the hospital environment became very apparent. She said:

> *I very quickly became completely naked, I just didn't want anything touching me, and it was really neat to feel so comfortable. I really did. I kind of forgot that I was in the hospital. We dimmed the light and we had music playing. They allowed us to really have our own space. . . . It just felt really organic and natural.*

Miller describes a hospital birth in which she felt so comfortable, "I kind of forgot that I was in the hospital." By expanding the idea of birth space from literal place (home versus hospital versus birth center) to include the importance of atmosphere in any environment many of the lessons from home birth can be applied to birth in a hospital.

For hospital-based midwife, Stanford, humility was critical in creating sacred space in a birth. She finished her interview by saying:

> *I just feel like anything that brings the birth experience to the feet of the people doing it, the parents and family, that's important. Creating that space where it's their experience.*

The idea that space can be created by maternity care providers suggests a middle ground for patients like Miller, who desire hospital birth, but still want care that emphasizes the religious or spiritual aspects of birth.

Stanford echoed the sentiment that the literal environment in which a birth takes place is less important than the feeling of security, trust, and respect engendered by certain providers. Stanford had a home birth, but she attributes most of the positive aspects of her birth experience to its metaphorical rather than literal space. Stanford described the home environment itself as less important than a feeling of security and trust in her providers. She said:

> *I was not so attached to where I birthed in that case. If any of the midwives [had suggested transfer] I would have been the first person in the car. It wasn't about the place. I really felt like if I closed my eyes or if I couldn't make a decision, that these people cared enough for me and knew me well enough that they could make*

> *it for me. They could see if I couldn't. I trusted them and that was just huge. And I think that that was more important: who and how versus where. It just happened to be at home. If I could've had that feeling of support and had a Kaiser birth,[32] I probably would have, I think I would've been happy in that space [the hospital]. But I love home birth; I love it.[33]*

In addition to trust and security in the maternity-care providers, the flexibility to allow family members and friends to be present was also a critical part of protected birth space in the hospital.

Shalwater describes her family being present as her favorite moment in her hospital birth. She said:

> *The whole family came down. They all live in the Dallas/Ft. Worth area. They had plenty of time to get there because my labor was so long. But they all got to the hospital and stayed there overnight in the waiting room because they wanted to be there, I guess. We kept saying, "You can go home. Go home or go to a hotel, or go to our house and rest. You don't have to stay here." But they all did. And that was really nice; that meant a lot to us. And so after Eli was born they all got to be there in the room with us and hold him. My husband broke down. He was crying when he saw his parents, when they finally came in.*

Lydia Marion, who was one of the few members of her community to plan an epidural, similarly described community participation in her birth as her favorite aspect of the birth experience. She described:

> *But you know like with Jane, we were over at James and Jennifer's*[34] *and it was Labor Day and they were having a big picnic and everybody was there. And I said, "Okay, well, I'm going to go have Jane", and they're like, "Woo! Woo!" So we're leaving in the car and our whole community is like, "Yeah!" I loved having people come visit at the hospital, I loved having the community around me. It [the spiritual aspect of my birth] was more about that.[35]*

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[32] A reference to the large HMO, Kaiser Permanente. Stanford means a hospital birth, funded by a large, inflexible insurance company.

[33] Barbara Stanford [pseudo.], interview by author, audio recording, 25 July 2010.

[34] Jennifer Martin, another interviewee.

[35] Lydia Marion [pseudo.], interview by author, audio recording, 5 May 2010.

For Marion, the spiritual aspect of birth was intimately related to the ability to feel that her religious community could participate in her birth.

MARION GRAVES WILDER, WATERBIRTH IN THE HOSPITAL

The hospital environment can be quite flexible in some circumstances. The following birth story, from Marion Graves Wilder, a mother of two in her early thirties, suggests the possible for intimate, individualized, and spiritually fulfilling care in the hospital environment. Wilder, who had her first baby in the hospital and a home birth with her second child, preferred her hospital birth. She describes several aspects of her hospital-based care that contravene the conventional wisdom that stereotypes hospital care as inflexibly routinized and unemotional.

Wilder went through many physicians to find a provider that fit. She described the process of finding a practice that fit with her personality and her expectations for her birth. She said:

> *I was just so impressionable, I was just terrified of having a baby. So this practice was six or seven . . . I saw a different person every time I went. There were six or seven obstetricians. Everybody was really nice, but it was like a ten-minute appointment. I didn't feel comfortable asking questions. I didn't even know what questions to ask. But I started reading everything I could and the more I read the more scared I got. And then I watched The Baby Story and was just, "Oh no! All this leads to this!" [A cascade of interventions.] It just started clicking: "If we start monitoring right away then the heart rate [might go down resulting in a cascade of interventions]", you know, all these things, so I was totally freaked out.*
>
> *So I hired a doula and she gave me a couple of names of obstetricians in [my city] . . . by then I wanted to explore natural birth and I felt like that would be healthiest and maybe the least intervention by avoiding an epidural.*[36]

[36] Marion Graves Wilder [pseudo.], interview by author, audio recording, 10 May 2010.

Wilder describes being afraid of the technological interventions that might characterize a hospital birth and feeling alienated by a large group practice that made her intimidated to ask questions. When she eventually found an obstetrician, Wilder describes asking a litany of questions, focused around specific interventions. She describes:

> *About six weeks before my daughter was born I got connected with this obstetrician. He was a professor at [the local medical school], had been forever, and he had participated in like a thousand births. And I walked in and he just met with me first. It was an appointment where we just met in his actual personal office.*
>
> *I had a check list and I was like, "What about this and this and this?" And I was just asking him, "What's your episiotomy rate? What's with this monitoring? Is that necessary? Do I have to have an IV?" Because they wanted me to be on antibiotics, just anytime I had dental work because [I had] heart surgery. So I was thinking, "Oh gosh, I'm going to be hooked up and if I'm hooked up then I'm not going to be able move." I was just terrified. So he was there and he took it [my questioning] and just listened.*
>
> *And then he said, "I can promise you one thing."*
>
> *And I said, "What's that?"*
>
> *He said, "This is going to be the most amazing day of your life coming along. It's going to be amazing."*
>
> *And I knew right then I was in good hands. And he's told me his episiotomy rate was about twenty percent; he was very open to not being on the monitor, and he said I could take [oral] antibiotics, I didn't have to be on an IV, it was fine. And then he said, "The nurses love to get that readout when you first go in so as soon as you go in, it's thirty minutes, let them get a strip and then you can get up." So I agreed to that.*

Recall Kevin Feldman's question from Chapter 3, when he asked about patients querying his reasons for cesarean section, "Are you trying to take a history on whether or not you trust me?"[37] Wilder's physician recognizes her list of questions as just that, a history on

[37] Kevin Feldman [pseudo.], interview by author, audio recording, 14 February 2010.

whether or not he can be trusted. He listens patiently and responds appropriately, first by reassuring Wilder that he can be trusted, and second by answering her questions more specifically. Rather than promising to avoid every intervention, he sets up a compromise with her, by telling her that the nursing staff will feel better if they are able to "get that readout when you first go in."

In the end, Wilder had a waterbirth in the hospital. She describes:

[I saw my doctor] maybe two or three times before she was born—I just saw him every week because by then, or maybe there was two weeks and then I saw him every week—I asked him about, I had seen a water birth video and the hospital had no tub or anything; they had a shower in the labor room. I said, "I really wish I could rent a tub and labor in water."

And then he said, "Well why don't you have the baby in water?" I mean, he was a midwife in scrubs.

I thought, "What? Really?"

He said, "Yeah, let's do it. You should do it. I think you should do it."

So I ordered this tub from Seattle and they Fed Ex'ed it to me . . . So then when I started labor David packed the duct tape and the tub and threw it in the car and we went to the hospital. Dr. William Henry was my doctor. I don't think he's in the hospital anymore, he retired. He brought this video [about waterbirth by]—what's his name, Michel Odent?—and had the nurses watch it. He was like, "You've got to see this. You ought to watch this video." And so it's like two o'clock in the morning and all the nurses are watching the video, and I'm walking the halls.

MPW: This is while you're in labor?

MGW: Oh yeah. They had no exposure to any of this. They were like, "What are you doing now?" He got no permission from the hospital, nothing. He was like, "Whatever, we're going to do it."

So I got in the water as soon as he said I was seven centimeters. I got in the water and it was amazing. He came in, he sat . . . He was really pumped. I was in transition. Both my births were like this. Seven centimeters; that was the longest part of my labor. So this is about seven o'clock in the morning. She was born at two or three that afternoon and born in the water. And David my husband was behind me in the water and Dr. Henry, I'm sure he did more than this but what I

remember is he kind of made sure things were okay and he just sat back and David pulled her up and then that was it. I mean it was just so easy—well, sort of easy—but it was really beautiful for me to go from all that fear and to have such a triumph like that. She was the first water birth in a hospital in [my state] . . . And then I got out and went to a bed and had the placenta. I had a small tear so they fixed me up there and then that was it. It was a great recovery. I just ordered a cheeseburger right away, hugged my baby; nursed her. It was amazing. I wouldn't change anything about that experience. And his nurse told me when I got back, "He said that your birth was his favorite of anything he ever did."

Wilder's had her second child at home, under the supervision of a home-birth midwife. Still, she describes her hospital experience as "the best." Wilder describes several disadvantages of giving birth at home that are not commonly discussed in the home hospital debates. Rather than focusing on access to back-up care, as many other interviewees did, Wilder describes missing the comfort of order and consistency that the hospital provided. She also experienced some trauma during labor and associated it with her house:

I have to say I had my second child at home and I had a great midwife; she's amazing. But my first birth was the best. It didn't quite work that way at home . . . We couldn't get the water hot enough. It just was a little more thrown together it felt like. I don't know . . . Well, I know some advantages [to the hospital]. The recovery. I spent so much time in my own bathroom in hard labor that after the baby was born, going back in there was kind of traumatic actually for me. I had spent so much time alone in there trying to get her to come and she was a hard birth. She was a bigger baby, she was nine pounds ten ounces. I wasn't prepared I guess for that.

Wilder also describes her physician as having been, in some ways, a more compassionate maternity-care provider than her home-birth midwife. She described:

I just thought I'd had such a good experience the first time and it [my home birth] wasn't a bad experience, it was just that it was . . . I don't know. . . . So I don't really know about it being at home versus the hospital or maybe it was the other people involved; I don't really know. Different personalities. My midwife, who I adore, is just a tough, strong woman, and at times I just wanted that soft cheerleader, and he [Dr. Henry, the obstetrician in my hospital birth] was that—which is so surprising because I never wanted a man.

She also described the difficulty of recovering without nursing support, saying:

> *Also the trauma of afterward. Being at home, I didn't have a good plan set up for afterwards because my mom — we had a small house [and] she felt like she was in the way. So she left and then my husband was exhausted too, because he had been up with me all night. So I think at one point the day I gave birth I was like, okay, let's have something to eat. [And I had to make food.] That was hard. None of this press a button. And I didn't do any of that when I was in the hospital but knowing that I could get somebody to help me. That security maybe.*

> *Everyone was really, really excited about my birth so I think my hospital experience was probably pretty different than what most women have because one of the nurses — I just totally lucked out — she had been through doula training or something. . . . so she was awesome to have. I remember saying "I'm hot," and there was a fan, and they brought popsicles, and I never asked for anything; they just catered to me so amazingly. And she [my nurse] came up--recovery was on a completely different floor--after the labor, delivery she came up the next day and said, "I just had to see you before you left and meet your baby again or see your baby again." And I just felt really special. And she went all the way to a different floor out of her way to come and tell me goodbye.*

For Wilder, there were many advantages to the hospital environment in terms of the emotional and physical support and comfort of nursing care that were lacking in the home environment.

Wilder's story is a *very* unique one, but I include it for several reasons. First it shows the potential for very personalized, patient-centered care in a hospital environment. Second, it destabilizes several major critiques of obstetric practice, providing an interesting counterpoint to the typical home versus hospital debates. Wilder experienced a male physician as a more compassionate maternity care provider than her home-birth midwife. Despite being very attached to the idea of avoiding obstetric intervention at the beginning of her birth, it was emotional support from a caring obstetrician, and compassionate hospital-based nursing support, rather than the avoidance of all obstetric technology, that made her hospital birth, "best." Wilder and her support staff were able to create an intimate birth space within the hospital environment. Finally,

rather than access to high-tech medical care, Wilder describes access to emotional and physical nursing support as the major advantage to the hospital environment.

CONCLUSIONS: NARRATIVE AND MEANING IN BIRTH

To conclude, I would like to return to the three transfer birth stories from the beginning of the chapter. Jane Rogers emerged from a highly technological birth and, "did not feel like I was less than a woman." Katie Freeman, by contrast, "felt like I was in a herd of cattle with a little number on my ear." And Meredith Marshall was, "thankful for the humility," of not being able to deliver "the natural way." Each birth story involved aspects of the home versus hospital debates discussed in this chapter in nuanced and interesting ways, and each highlighted the important role that constructing a birth story can have on the spiritual or religious message that women derive from their experiences.

Rogers was able to experience a highly technical birth and still maintain a second narrative of her birth as a spiritual event. She said: "When people ask about my birth. I tell them that I distinctly had two births. I gave birth to myself as a mother at home, and then I went to the hospital to get my baby out. And I feel very blessed to see it that way." Rogers' statement, "I feel very blessed to see it that way," suggests an attention to the importance of narrative construction in the emotional and spiritual meaning women and their partners take from their birth experience. In his discussion of the problems attendant in editing illness narratives for publication, Arthur Frank writes about the fluidity of stories as they relate to experience:

> The truth of stories is not only what was experienced, but equally what becomes experienced in the telling and its reception. The stories we tell about our own lives are not necessarily those lives as they were lived, but these stories become our experience of those lives . . . . Life moves on, stories change with that

> movement, and experience changes. Stories are true to the flux of experience, and the story affects the direction of that flux.[38]

Like an illness narrative, a birth story is not simply an unbiased account of events that took place during a birth. Particularly when birth stories focus on religious or spiritual experiences, the narrative framework that a story is integrated into matters a great deal. To some extent, as in Rogers' case, the narrative that gets constructed can determine how an experience will be understood, since the events in a story are restructured and endowed with different meanings through the process of narration.

The alternative birth movement itself presents a series of powerful narratives that at their best can empower and enliven the experience of birth, but at their worst, these same narratives can traumatize women and their partners. Lyerly writes:

> With the "natural" birth held as the ideal, the decision to use anesthesia can be experienced as a failure. Women anticipating labor will say, "I am going to try my best to deliver naturally." For those who change their mind or find themselves in a situation in which a "natural" birth is not possible, who need anesthesia or a cesarean section, there is often a sense that they just didn't have what it takes, physically or mentally, to have a child the way their grandmother did. This sensing too, as apprehension of self as inferior or defective, can be just as disempowering as the shame induced by the antics of a masculinist man wielding technology . . . . Yet this shame is a result of what is thought to be an empowering birthing movement for women.[39]

While women can be empowered beyond measure when they are given a narrative of birth as a natural, life-cycle event, they can also be traumatized by a formulation of a less-than-natural birth experience as a disempowering violation. Resistance to routine and ritual in birth, in its more extreme forms can also result in traumatization, as in the cesarean birth Miller described earlier.

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[38] Arthur W. Frank, *The Wounded Storyteller: Body, Illness, and Ethics* (Chicago, IL: University Of Chicago Press, 1997), 22.
[39] Lyerly, "Shame, Gender, Birth," 114-115.

As Lyn Callister points out, part of the work maternity care providers can do is a kind of narrative reintegration through eliciting patient's birth stories. In addition to the importance of controlling the actual events that occur in a birth, doulas, nurses, midwives, and physicians can assist women and their partners in redefining the meanings of obstetric rituals and routines. This reaffirms the importance of birth stories to maternity care. For example, an integral part of the *Birthing from Within* model is identifying the rituals and symbols present in modern obstetric practice and going through a process of redefining them. Parents are asked to make lists of the obstetric symbols, and examine both the personal and cultural messages those symbols send. England writes:

> During the final step of this process, parents are asked to assign a new meaning to each symbol (it can be positive, negative, or neutral). This task helps parents transcend their original, unexamined assumptions of what a particular symbol communicates. Parents begin to understand the freedom they have in responding to symbols in their medical birth environment.[40]

Roger's attachment to the *Birthing from Within* model may help explain why she was able to appreciate the highly technological and routinized birth experience, and still "not feel like my birth was defined by it." She emphasized her interpretation of the birth experience alongside the actual events that occurred with the statement, "I feel very blessed to see it that way."

The narrative integration that takes place after a birth is particularly informative to spiritual or religious interpretations of birth. Particularly with women who identify with a specific religious tradition, it is often the telling and retelling of a birth story, rather than the phenomenological experience itself that helps them understand the religious significance of the birth. Meredith Marshall, for example, emphasized the way her

[40] Pam England and Horowitz, " Birthing From Within Holistic Sphere," 5.

understanding of the importance of her birth changed in retrospect. While her subjective experience of birth was defined by the extreme experience of physical pain, the narrative she tells in retrospect may be much more significant from the perspective of religious or spiritual experience:

> *In retrospect—through that whole thing the best moment was just having the pain relieved at the very end because at that point it was just such a physical need—but in retrospect, my Mom wound up coming in the morning that she was born . . .*
>
> *We were having a really hard time and it had been Mike and I and the midwives sometimes coming into the room and at some point I was like, "Mike just go get my Mom." I've never been super close to my Mom . . . we didn't always connect and I've always been a very private kid growing up. So I would never have expected to want her in the room with me . . . I would have felt like it added pressure and not [comforted me] . . . but I was wrong about that: It wound up being a very comforting thing. When she finally came in I was sitting in the shower; they say it's supposed to help. [laughs sardonically] When I saw her I just started bawling, and I don't think I've been that broken in front of her since, I don't know when. Because I just felt, I said, "Mom I just don't think I can do this." And at that point, that was still way before we finally did throw in the towel, she stayed with us from that point on, which was an excellent relief to Mike . . .*
>
> *She's an excellent doula, as it turns out. I mean she was very good. And I know she was praying like mad the whole time; I could see it in her face. I was in a place where prayers, words, sentences, they weren't exactly coming to me. I was just in that spot of relative peace, you know worrying about it isn't going to help, you just have to kind of get through it. So I would say I was in a spiritual spot with it, and even into the hospital. I think it was really nice to have her there because she'd been through this, she'd been through birth several times and I knew, I knew she was just praying like mad.*
>
> *So in retrospect I think that level of closeness or having shared that with her, and certainly her feedback afterwards, was very reassuring, saying stuff like, "You know, you could have given birth three times with that amount of time and that amount of energy." Just being really reassuring and saying, "You did everything you could," and just really saying the things you need to hear.*
>
> *Whenever you feel like it didn't work out the way you hoped. . . . Mike is not a very emotional guy, and certainly most guys couldn't say all the things you need to hear, which your mom can say, even if you haven't necessarily been super*

> *close to your Mom all of your life. In retrospect that was, I think, a very good aspect of it: to have that part of the relationship . . . renewed. That was good.*[41]

After our interview, I received an email correspondence from Marshall suggesting the importance of a neutral space in which to talk about the "goods and bads" of attempting an unmedicated birth and eventually having a cesarean section. She wrote:

> *I feel like I should have paid you. I at least owe you a huge thank you. There was something VERY therapeutic about talking to a nonjudgmental person who had no vested interest in my answers other than for basic data. Giving birth really ranks up there in terms of significant experiences in my life (of course). So discussing the goods and bads of that in a "safe place" is really something valuable. Thank you for being such a wonderful listener!! I benefited enormously from sharing these thoughts.*
>
> *We talked a lot about what made my setting(s) and experience spiritual. I decided afterward that really ANY experience has the potential to be spiritually significant, based upon the intentionality going into the experience, or especially, the reflection afterward . . . even regardless of what happened during.*

While the majority of discourse about American birth, both in scholarship and activism, has focused tightly on the location in which a birth takes place, and the degree of technological intervention that occurs, women themselves often tell a more complicated story. The stories of individual women can be a powerful force in improving American maternity care: Listening closely, and with a keen ear for their more subtle features, one finds that these stories not only transcend dogmatic ideologies of religion, but also destabilize the polarized and contentious ideologies of childbirth, which can be equally as dogmatic.

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[41] Meredith Marshall [pseudo.], interview by author, audio recording, 18 March 2010.

Chapter 6:

Beyond the Curse of Eve: *Pain, Choice, and Moral Bricolage in Christian and Jewish Childbirth Narratives*

> *To the woman he said, "I will greatly multiply your pain in childbearing; in pain you shall bring forth children."*
>
> *-Genesis 3:16, NRSV*

Jennifer Martin is a young non-denominational Christian and a mother of two. Martin and her husband, Bret, live in a small, cozy house in a neighborhood filled with friends from their progressive, church community. Jennifer and Brad have two children, Frank, who is almost four, and a new baby daughter, Janie, who hungrily woke up from a nap mid-interview. When I arrived for my interview, Bret was gathering eggs from the two chickens the family has in the backyard. The couple is dedicated to an ideal of living simply in a community based around love and service. For this reason, when Jennifer became pregnant, they immediately gravitated towards midwifery care. Bret explained:

> *I think that's just part of our personality. That's what we connected with. That's what we initially felt we wanted to do and then when we met with these specific midwives we really connected with them. When we talked about it, it didn't ever make sense for us [to have a traditional hospital birth] — maybe it does for some people but for us it didn't make sense. We thought, "Well why would we go do it this way when women have been giving birth this [other] way for hundreds of thousands of years? . . . This is how God created the woman's body. She can do this; she doesn't need all these other things." If she wants to choose them then that's great, but Jennifer didn't want to. She thought, "God made my body to do this and I want to do this."*[1]

[1] Bret Martin [pseudo.], interview by author, audio recording, 22 March 2010.

In addition to tying midwifery model care to their religious beliefs and personality in general, both Bret and Jennifer related to the idea that labor pain was a natural and important aspect of the childbirth experience. Although Brad made sure to add the caveat that some women make other choices and, "that's great," Jennifer described believing that the experience of pain in birth was part of God's intention in creating the woman's body. She explained, "I felt that feeling it [pain] was important—that there was a reason that we were meant to feel it that way, too."[2] Especially when she gave birth to her second child, Janie, Jennifer perceived her labor pain as normal, and highly relevant to the religious and spiritual aspect of her birth. In contrast, during Frank's birth, labor pain was so extreme that it felt nothing like the natural fulfillment of divine order she experienced when Janie was born. Jennifer's first birth started at a birth center. But when it was time to push, her baby had trouble descending and labor quickly became excruciatingly painful. She describes:

> *My contractions were coupling so I'd get two back-to-back, a forty-five second break and then I'd get another one, and then I'd get another forty-five second break, and two more back-to-back. I was also having back labor . . . Really long story short with Frank: I wound up pushing for five hours and he was very stuck. He was turned around and he was presenting on the side of his head . . . He just wasn't getting through and it felt like the worst of everything with the coupling contractions and the back labor. I looked at Bret and said I was going to try pushing him out one more time and then we were going to go to the hospital; I was exhausted. I felt my body just bearing down on him trying to get him out and it wasn't happening.*

Jennifer recounted her hospital transfer during Frank's birth:

> *We called the ambulance, they came and got us and took us down to [the hospital]. Bret was in the front seat . . . . At this point I had lost all composure and was just that very typical screaming and shaking, and that poor guy in the back with me. When [Bret] got out of the ambulance . . . he tells me now, "I*

[2] Jennifer Martin [pseudo.], interview by author, audio recording, 22 March 2010.

thought there was a gunshot victim or something, all I heard was this insane screaming"— and then he realized it was me. They wheeled me through the emergency room and my mother and father-in-law were in the waiting room and my mother-in-law told me that when I went by my father-in-law said I sounded like I was possessed by Satan. I was just very vocal. And so when we got in the emergency room, I went from one midwife and my husband to all of a sudden I felt like there was like ten nurses are on me, and I felt very safe. They were all like, we're going to take care of you, this will be fine, and I was just pleading just get him out.

In general Jennifer ascribed a positive and religious significance to pain in birth, describing it as something that, "we were meant to feel," but after her intensely painful experience giving birth to Frank, she described being open to the possibility of epidural anesthesia with her second baby. She explained:

In my second one, I was open. [I decided,] if it gets to where it was with Frank, I'm probably going to get an epidural. And Bret was the one [saying], "Well, that's fine but I think you can do it." I [said], "I know I can do it but if it gets to that place . . . " And he agreed with me because that was torture, that wasn't childbirth.

Ultimately, Jennifer had an unmedicated birth with her second baby—a short and beautiful hospital birth, which they documented and shared with me in a moving photo essay.

Martin still very much believes that pain is an important aspect of birth, and that God created women's bodies to give birth without medical intervention, but she tempers her statements with personal experiences from two very different births.

MPW: Did your spiritual beliefs play into your desire to want to have a natural birth?

JM: Oh yes. I definitely believe that. I hesitate to say it too much this way because I don't ever want to come off that I feel like women who have medicated births aren't doing what their body was created to do. I just very much believe that God created my body this way, to be able to do that and it is kind of a badge of honor.

And I felt that feeling it [pain] was important, that there was a reason that we were meant to feel it that way, too. And with Frank, not so much, because it got to

> *such an extreme place where I just all of sudden couldn't feel much of anything but that one central pain. But with Janie I really . . . I really could feel everything that was going on and I felt so in control — except for the obvious process of her doing her job — and I thought that was great. I mean, it was pretty much between me and my husband the doula, that we got our baby out.*

Jennifer also referenced the biblical passage from Genesis 3, commonly interpreted to describes pain in childbirth as a punishment for sin. She disagreed with this common interpretation, saying:

> *I don't think it's a punishment. I mean I know that in Genesis, women ate of the tree, and God said that that [pain] was going to part of it. But I think it would be a completely different experience if delivering was painless. I don't think you'd feel as special — to me anyway it would have felt as special. I feel like I worked hard — hard — to get my babies in this world. Real hard.*

Jennifer Martin's experience with two very different births helps contextualize many of the issues around pain in childbirth as it relates to religious experience under Western monotheism. Like many of my Christian and Jewish interview subjects, Martin relied on the idea that women's bodies were created by God to labor without pain medication. Her birth stories point to the potential to experience unmedicated birth as spiritually and religiously significant in a positive way, despite the common idea of childbirth as the curse of Eve. At the same time, her experience with extreme pain (which she describes as torture) in her first birth, along with her husband's insistence that women should be free to choose epidural anesthesia, underscore to the importance of access to epidural anesthesia, the centrality of choice, and the individualized nature of each birth.

This chapter focuses on narratives from Jewish and Christian women, examining the ways in which they frame experiences of pain and choice in childbirth. Though religious texts from these traditions sometimes characterize pain in labor as the curse of Eve, the women I interviewed often experienced their labor pains as empowering, and sometimes-visionary spiritual experiences. These women use what philosopher Jeffery

Stout has called moral bricolage to sacralize their experiences of birth under monotheistic Western traditions.

The first part of this chapter will focus on the struggles my Jewish and Christian interviewees faced in framing their experiences of unmedicated birth as religiously significant. Like the Martins, these women often described their experience in terms of feeling like their bodies were created by God to be able to birth without medical intervention.[3] At the same time, this idea created a tension in narrating their birth stories to other women who sometimes felt negatively judged for having more medicalized birth experiences. Balancing an experience of labor pain as religiously significant in a positive way with the importance of maintaining a non-judgmental stance towards other women often took the form of emphasizing choice as a central component to the childbirth experience. By positing birth experiences as highly individualized and personal choices, women were able to both validate their own experiences in a religious context, and at the same time avoid condemning the experiences of others.

The second part of the chapter will focus on the acts of moral bricolage that Christian and Jewish women utilized to sacralize the embodied experience of labor in the context of religious texts that often stigmatize that experience. Rather than viewing labor pain as a curse, when they were able to choose to experience labor pain willingly, women often experienced it as redemptive, connecting, and fulfilling. I will also focus on examples of moral bricolage in a written birth story by one of my interviewees, an Evangelical Christian named Penelope Hull. Hull's story illustrates the potential for sacralizing embodied feminine experience using masculine oriented biblical texts. Rather

[3] Interviewees occasionally extended this logic to include conception as well, believing that God should control their fertility.

than focusing on biblical references to birth, Hull uses masculine, and often military passages, reframing them so that they speak to her personal experience during birth.

LABOR PAIN AND CHOICE IN BIRTH PRACTICES

Some of the most noteworthy acts of moral bricolage I encountered from Christian and Jewish women related to the experience of pain during childbirth. Perhaps no issue in the birth world is more contentious than labor pain. Obstetric anesthesia has been the subject of heated debate among childbirth activists since its inception at the turn of the nineteenth-century. The history of obstetric anesthesia is rife with controversy informed by religious debate. Most famously, pain in childbirth appears in Genesis 3 alongside unequal gender roles in marriage, the necessity of difficult agricultural labor, and in some interpretations, mortality, in the list of consequences that God recounts to Adam and Eve just prior to their banishment from the Garden of Eden.[4] One interpretation of this text, which was still quite popular in the nineteenth-century, suggested the guilt and shame of original sin manifest themselves at the level of women's bodies through birth pain. The widespread debates that took place during the popularization of anesthesia at the turn of the century were particularly influenced by these religious arguments in the case of obstetrics. But while the association of childbirth with original sin, and the explanation of pain in birth as, "the curse of Eve," led some nineteenth-century critics to suggest that the use of ether during childbirth was an attempt to subvert divine order, while others suggested its advent was a sign of divine grace. [5]

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[4] E. O. James, "The Tree of Life," *Folklore* 79, no. 4 (December 1, 1968): 241-249.

[5] A. Franco and J. C. Diz, "The History of the Epidural Block," *Current Anaesthesia and Critical Care* 11, no. 5 (October 2000): 274-276; William Osler, *Man's Redemption of Man: An Address Delivered at the University of Edinburgh in July, 1910* (New York: P. B. Hoeber inc, 1937); Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750 to 1950* (New York, NY: Oxford University Press, 1986).

Anesthesia in childbirth stands apart in many ways from other technological interventions in birth. In contrast to technological interventions like electronic fetal monitoring, pitocin augmentation or IV administration of fluids, only two interventions, cesarean section and epidural anesthesia, are thought to alter a birth experience so radically it no longer qualifies as "natural childbirth." The term, "natural childbirth," common in the 1970's and 80's, has become controversial for several reasons including the difficulty in defining the term natural, and the stigmatizing implications that women who give birth with medical intervention are doing something unnatural. The more neutral term that has replaced it, "unmedicated childbirth,"[6] focuses even more tightly on the absence or presence of anesthesia. Furthermore obstetric anesthesia, unlike cesarean section, carries the added weight of being generally non-emergent, thereby opening the possibility for tension and judgment of birthing women in a way that cesarean section generally does not.

Obstetric anesthesia is already a tender subject for contemporary women; but in the context of Western monotheism, the Genesis story presents a particular challenge for women who associate unmedicated birth with spiritual or religious experience. These women face two challenges. First, suggesting that unmedicated childbirth facilitates the experience of birth as religious or spiritual is controversial. Women and midwives who interpret the experience of labor pain in a religious or spiritual framework must take great care in how and where they tell their birth stories because of the difficulty of engaging with other women who might feel negatively judged for accepting anesthesia. Second,

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[6] I should point out that the term, *unmedicated birth* is similarly imprecise since many unmedicated births take place with one or more medications present, for example pitocin, cervical ripening agents, or antibiotics. But since the term *childbirth without anesthesia* is both cumbersome and unpopular, I will use *unmedicated birth* for the purposes of this paper. It removes the morally loaded word *natural* and was used by many of my interviewees.

women from Abrahamic traditions face the added task of engaging with a religious tradition that characterizes pain in childbirth as a punishment or curse. Women often reconciled these two problems by suggesting the importance of viewing anesthesia as an individualized and personal choice.

Many of the patients, midwives, and doulas I spoke with attached a positive spiritual or religious significance to the experience of pain in labor. Midwife Margaret Heinley, for example expressed the idea that birth without epidural anesthesia is particularly ripe for spiritual experience. She said:

> *Natural childbirth—and when I say natural childbirth I mean unmedicated childbirth—in someone who wants to do it—any time you have pain you don't want you can be traumatized by that pain. But if somebody wants natural childbirth, or they know they have to do it and they just face it down, it takes many spiritual qualities. It takes faith. It takes determination. Commitment. It takes courage. Those aren't emotions. I don't think those are psychological things, I think those are spiritual. When women come out on the other side of it, yeah there's this joy of this new baby, which people can have that if they've had a c-section. But what the woman also has is, it's not exactly like running a marathon, but it's kind of like that. You know, "I had no idea I could do something so hard." Women find their depth.*[7]

Heinley points to the critical role of choice in the perception of labor pain as spiritually significant. She describes unmedicated birth as a potential source of spiritual experience, but at the same time she also points out that unwanted pain can result in trauma. Molly Smart Wilkerson similarly described the experience of empowerment via choosing to experience labor pain. She described the moments after her unmedicated hospital birth with doula support, saying:

> *I'm sitting there with [my doula] and I said, "This is the strangest feeling of my life. I know I just had a baby and it's not here anymore." It was all so fuzzy and weird and great. It was ultimately really empowering for me. And it's weird*

[7] Margaret Heinley [pseudo.], interview by author, audio recording, 12 May 2010.

> *because your body's made to do that, right? Most women's bodies are made to have a baby and push it out and do all those things. But for some reason, being one of the few women that chooses to not do the pain medicine is really incredibly empowering. And there's, of course, a point of pride, too, because Charlotte, when she was born . . . when her head was out and her shoulders were still inside [my doula] said her eyes were wide open and looking around and she was so alert from the get-go. There was nothing interfering with her at all. It happened the way it was supposed to which was really cool.*[8]

Wilkerson's descriptions, "Your body's made to do that," and "It happened the way it was supposed to," are examples of a recurring theme. Women often relied on these concepts when describing the embodied feminine experience of birth as having positive religious or spiritual significance. Both Heinley, who calls herself a "cultural or secular Catholic," and Wilkerson, a liberal, pro-choice, Lutheran, identified spiritual aspects of birth that manifest themselves more readily when it is unmedicated. This is a common, but controversial opinion since, as I discussed in Chapter 5, the decision to use epidural anesthesia can also be experienced by some women as a failure, thereby adding to the experience of birth as traumatic, rather than alleviating it. This problem is heightened when religious language comes into play since, for many women the religious significance of unmedicated birth is intimately tied to a feeling of doing in Wilkerson's words, what, "your body is made to do," or even more provocatively, in Martin's descriptive terms, "what God created your body to be able to do."

Pamela Klassen writes of women who choose to deliver without anesthesia, "their commitment to experience the now avoidable pain of birth in a culture that is generally averse to pain generates a combination of condemnation and awe from several quarters."[9] Because of the condemnation and awe that Klassen describes, many women who attach

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[8] Molly Smart Wilkerson [pseudo.], interview by author, audio recording, 17 March 2010.

[9] Pamela Klassen, *Blessed Events: Religion and Home Birth in America* (Princeton, NJ: Princeton University Press, 2001), 176.

spiritual significance to the experience of pain in birth temper their statements with modifiers that address women who choose anesthesia. Midwife Marcia Ryan expressed this sentiment, appending her comments about the desacralizing aspects of epidural anesthesia with the caveat, "I don't believe in making women feel bad about themselves." She said:

> *An epidural is going to completely numb this whole part of [your body].*
>
> *Physically, you're uninvolved. You know what you're doing, but you don't get to participate because you don't feel any of it. So you're sleeping or watching TV or playing cards and you're completely separated from the reality of the process . . . because you don't get to feel any of it.*
>
> *I'm really careful [to avoid] saying that there's no value in that, because there still is, you're still giving birth to your baby. I don't want women to feel bad about asking for an epidural either because (laughs) I don't believe in making women feel bad about themselves. I think there's enough of that going on.*[10]

Ryan's sentiments point to the possibility for childbirth activism that advocates for unmedicated birth to either empower women, or to result instead in feelings of failure by women who do use anesthesia.

The tension over anesthesia can also act as a barrier to women's ability to narrate their birth stories. This is no small problem since, as I have discussed in detail earlier, the narration of birth experiences can function both as a brave moral act and a vital therapeutic tool. Reflecting on her hospital birth without anesthesia, which she describes as an extremely positive and meaningful experience, Christine Chandler Miller described being limited in her conversations with other mothers. She said:

> *I try to be real careful at talking about my birth story around the women who didn't have a natural birth.*[11] *I find that if someone asks my birth story I try to*

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[10] Marcia Ryan [pseudo.], interview by author, audio recording, 18 March 2010.

[11] Miller's term, "natural childbirth," common in the 1970's and 80's is less preferable today for several reasons including the prevalence of many technological interventions in births that are considered

> *always mention it was a total personal experience and I think each woman has their own choice, and I always want to make sure I'm not passing judgment or making someone else feel [negatively judged.] . . . Because I had such a positive experience I feel timid around women who have had hard births because I'm afraid—I don't want to be hurtful. It's a funny place to be on the other side, too, because you feel like you want to share your story but you don't want to . . . I would never want to make someone feel bad.*

Notice that both Miller and Heinley emphasize the importance of individuality and choice in terms of experiencing labor pain. But while Heinley emphasizes the importance of a woman's ability to choose pain in terms of her ability to experience natural birth as spiritually fulfilling, Miller uses the concept of choice to contextualize her birth as an individual and personal experience, the narration of which should not be taken as a condemnation of another woman's different experience.

Mollie Smart Wilkerson also emphasized the importance of viewing birth decisions as intimate, individualized, personal choices, and pointed to the way women with positive spiritually significant birth stories can feel silenced. The tension is twofold: First, women were sensitive to the possibility of seeming judgmental of women who chose epidural anesthesia by narrating a positive birth story about unmedicated birth. Second, narrating a story about a low-intervention birth also raised the risk of being negatively judged by others. Wilkerson described:

> *My friend, who followed her son in his bassinette [after an unmedicated birth], said, "I had to stop talking about it to my friends." I'll give you her name because she loves to talk about it and she had a doula and it was really cool for her. She's a very spiritual person . . . She said, "I had to stop talking to people because they were so resentful." And I don't think it's resentful of that you did it; I think it's resentful that you're happy. My friend Shannon [for example] loves her son and*

"natural," and the difficulty of defining what is natural. Commonly, the term "natural" hinged almost entirely on the presence or absence of epidural anesthesia and cesarean section. In this way Miller's birth, which took place in the highly medicalized environment of a hospital and included IV administration of fluids and glucose, can be characterized as a "natural birth" despite the presence of a great deal of medical and technological influence.

> *she loves his birth because that's what got her to him, but . . . I know that she didn't love the experience. And there's a picture of her with her mask on because she was like this when she found out she had to have a C-section. There's actually a photo of it on the internet.*
>
> *And I never had that moment: I never had that moment of giving in. I never had it. And that doesn't mean that I care that anybody else had it. One of my very close friends whom I'm actually going out with today, she had to get an epidural because her birth wasn't progressing and she couldn't relax, she was throwing up after every contraction, she was miserable and that's what made it not miserable for her. But I don't get the feeling that she resents it.*[12]

Wilkerson also described the importance of sharing birth stories:

> *I've thought about that a lot, like what makes people so hostile and resentful towards each other's choices. I think part of it might be competitive and maybe because that's I'm competitive and so I put that on other people. But I also think that it's just so personal and it's so easy when something is so personal to feel insulted. I can see that feeling like an insult to somebody. It is strange. But it's nice because I do have people in my life that I can talk to about. And I remember you just want to share your story, it's so personal. And I invested so much time and energy and work into making that birth experience the way that I wanted it to be and I was really fortunate that it did [turn out well], because obviously there are people that do everything that I did and it just doesn't work out. But you want to share it because it's cool and it's empowering and it's amazing and it's one of the only times in your life I think where it's so elevated and like this is what your body can do, this is what your body's made to do, and that's so cool.*

Wilkerson describes the intimate and personal nature of childbirth, suggesting that, though this is what makes it "so . . . easy to feel insulted." Ironically the personal nature of birth also relates to the importance of having a forum to, "Share your story."

Marion Graves Wilder, who had the hospital waterbirth described in detail in Chapter 5, similarly mourned what she described as a lack of "space" to talk about birth. Wilder contextualized birth within the larger framework of women feeling judged with respect to parenting decisions in general. She said:

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[12] Mollie Smart Wilkerson [pseudo.], interview by author, audio recording, 17 March 2010.

> *[With] birth, I feel like there's not a space to talk about any of it really, especially a natural birth. And this doesn't end with birth. This is breastfeeding [versus bottle-feeding]; this is the stay-at-home, go-to-work debate; all of those things. Whatever choice a mother makes, there's someone who didn't make that choice. So there's this rift. Not a rift but this opposition that is really stressful. I feel like if I talk about the birth, the way I birthed babies, I'm going to be offensive to someone. You know what I mean? Because they're going to think that [I think my way was better]. And obviously I do think my way is better. It was better for me.*
>
> *I think breastfeeding is important, but I also have a supportive husband and I was able to have the space to do that. I do regret that [tension over women's choices], that that's the way it is. I feel that's the way it's evolved. And now whether a mom stays at home or goes to work, whichever she chooses there's somebody who's doing it a different way . . . But birth specifically, it's really hard.*
>
> *I also had a friend who was with me at my second birth. She was there, too, at my house. She had not had a child before. She was pregnant like three days later after my birth, which is really cool. She had a natural birth. I know that she's told me that it definitely played a part in her decision because she saw it happen. But she's told me, too, that she felt like she can't talk about it with some of her other friends.*[13]

Wilder, who had a home birth with her second baby, also described a reciprocal perception of feeling negatively judged when she told other women she had a home birth. She recounted:

> *The other day . . . I said something about, "It's kind of hard to move out of my home, I had my second child there." I was at my daughter's elementary school and I was talking about it. And a mother immediately said, "Oh, well if I had my daughter at home she would've died because she had dystocia." That's the kind of conversation that [can happen if you tell your birth story] so mostly I don't talk about it because of that. I don't want to hear [comments that are so] critical. It's scary. I mean what if I do have other kids? I'm going to remember that, that she said that. I don't know what led to that. I don't know if she walked around or if it could've prevented. Maybe not. I mean it is scary.*

Wilder's observation, that mothers can feel negatively judged whatever their birth choices may be, suggests birth as only one part of the public judgment mothers face in

[13] Marion Graves Wilder [pseudo.], interview by author, audio recording, 10 May 2010.

contemporary American culture, which is still transitioning after the women's movements of the 1970's. Childbirth becomes another issue in the culture wars, in which women can be stigmatized either for embodying traditional maternal roles, or for giving the impression of neglecting them.

The women I interviewed were generally quite sensitive to the threat of judgment that pervades choices related to parenting. For this reason, even very religious women, who tied their religious beliefs specifically to birth, emphasized the importance of respecting the choices of other women. Shelby Whitman, for example, is a Fundamentalist Christian and a mother of eight. The Whitmans are a home-schooling family who believe strongly in the idea of letting God control fertility. When I interviewed Shelby Whitman in her spacious suburban home, five of the older children were busy studying at the dinning room table. Whitman, who was pregnant with her ninth child, explained:

> *We just try to be open to the lord. In scripture there is a lot about God opening and closing the womb. It says that the creation is groaning. There are also allusions to God being in control of fertility. There's a whole movement of people who want God to control their fertility.*[14]

But while she believes strongly in the importance of avoiding birth control for religious reasons, she still emphasized the importance of respecting the different choices that other women make. She described:

> *I'm different in that I wanted God to help us decide how many children to have, and I didn't want to use birth control. I didn't want to do anything that would kill a baby in any way. God created my body, and I struggle with breaking something that God made. At the same time I respect people's choices. God knows my heart and that my desire is to please him. We're trusting him that he knows whether or not they should come.*

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[14] Shelby Whitman [pseudo.], interview by author, 27 September 2010.

Whitman's respect for other women's choices is particularly striking considering that she described wanting to avoid any potentially abortifacient effects of birth control in terms of something that might "kill a baby," and she recounted a troubling feeling that regulating fertility pharmacologically might be tantamount to "breaking something that God made."

Debates about midwifery versus medical model maternity care often take the form of statistical arguments over clinical evidence. Some of my interviewees problematized this form of rhetoric, suggesting that childbirth choices were often (appropriately) motivated by other factors. The fear of judgment or appearing judgmental that many women expressed also came from sources other than individual birth stories. Stevie Shalwater, for example described how her childbirth educator advocated for unmedicated birth in ways that made Shalwater, who had an epidural with her first birth and an unmedicated homebirth with her second baby, uncomfortable. She described:

> *I think there are some groups of people, like in my Bradley class, my Bradley teacher was way for not having an epidural. She was really obvious about it, kind of talking about some scary statistics that I just don't think were necessary. I think we're all responsible to self-educate ourselves whether we go to doctors or midwives or whatever. You don't need to use scare tactics to try to convince somebody to not [have an epidural] . . . You either want the pain or you not want the pain; you either care or you don't. I definitely think it's some people are like "I don't care if I . . . I don't want to feel any of it, I just want to have my baby"; and some people really want to experience it. That's just two different types of people.*

For Shalwater, the Bradley instructor's emphasis on the possible side effects of anesthesia missed the point. Some women want anesthesia, and others do not: the decision is an intimately personal choice. Doula and childbirth educator Jane Rogers reiterated the idea that the decision to choose epidural anesthesia versus not hinged on something other than a scholarly perusal of medical evidence:

MPW: Do you think there is a tension between women who want epidural anesthesia and those who don't?

JR: Absolutely. Absolutely. And it's all about them just not seeing each other. Not seeing eye to eye. One woman might see that it's her right to have pain relief, to have an epidural. And that does not come from reading New York Times articles and perusing medical journals, that belief comes from very early on. The same is true from the home-birther who absolutely does not want an epidural to be any part of her birth . . . That [belief] came from long ago. And so they have a lot in common in that they didn't decide these things the moment they got pregnant. In fact they didn't consciously choose these things at all. They are so unconscious, these ideas. And part of my job as a childbirth mentor is unraveling this and . . . uncovering the root of that belief. Only when she can be conscious of her belief can she really choose anything.

Contextualizing the decision to use or not use anesthesia as an intimate and personal choice allowed women to avoid the perception of feeling negatively judged, but both Rogers and Shalwater problematized the idea, common in many birth advocacy circles, that choosing midwifery model care is a completely rational and evidence oriented decision. Rather, Rogers suggested, there are many unconscious factors that contribute to the choices women make in birth. Rather than advocating for any specific model of care, Rogers views her job as a childbirth educator as helping women understand the reasons behind their choices. As an example, she described one of her clients, a woman who was planning a homebirth. Though Rogers supports home birth, and attempted a home birth herself, she does not believe that home birth is right for every woman. She explained:

[I have a client, and] she is planning a home birth. And everything that she said was about being utterly convinced that home birth is the best thing for her and her baby. Being utterly convinced that pain is a choice to be made in childbirth . . . [and that] consciously she could experience pain and choose to experience it or not . . . I made it my project to help her uncover where this is coming from . . . After we finished [the class] we had an email exchange . . . She emailed me and said, "Oh by the way I've decided to have my baby at a birth center instead . . . I realized that I was really afraid to have a home birth. "

I feel a huge amount of success around that because a woman who is planning a home birth and yet the very core is afraid of home birth, that is trauma waiting to

> *happen. For someone who at the core is afraid of homebirth, there is no way possible that that person is going to have a home birth gracefully . . . . I don't know how her birth is going to go, but at least she's done something empowering; she has uncovered something. I know that she's done some really deep digging and that can only be good for this profound initiation she's about to experience. So she thanked me for helping her get really clear.*[15]

Though she is also a home-birth advocate, Rogers sees her role as a doula and birth educator as facilitating a woman's ability to make choices that are right for her as an individual. Obstetrician Samantha Percival similarly described the importance of empowering women to make choices about place of delivery that fit their individual needs. She described her practice:

> *We're pro-choice in the complete sense, in that we are in favor of women choosing their own birth location, and we encourage women to search out all their options before they make a decision, and figure out where they're going to feel the least anxious and the most safe. And for some people that's going to be the hospital where they have the safety net of Western medicine. But for other people being in the hospital creates such an anxiety that it's actually going to interfere with their birth process [so they should consider entertaining the possibility of a home birth.] People make all sorts of different choices. So much of that is about empowerment for the woman to control her circumstances.*[16]

LABOR PAIN AND BIBLICAL NARRATIVES

> *I'm thankful that God allows humans to come into the earth this way because he didn't have to do that, you know? It could be any way that he wanted. There's something so evident of his love. There's just a purpose. There's something in the way that he did that. Because we're sinners! [He didn't have to do that.] There's just something so gracious that He allowed us to do that.*
>
> *-Christine Chandler-Miller*

In addition to the narrative constraints engendered by a positive experience of unmedicated birth in terms of feeling judgment, Christian and Jewish women also had to grapple with religious traditions whose primary texts sometimes construed labor pain as

[15] Jane Rogers [pseudo.], interview by author, audio recording, 15 June 2010.
[16] Samantha Percival [pseudo.], interview by author, audio recording, 13 June 2010.

spiritual punishment. Though many women mentioned Genesis, none of them overtly identified pain as a punishment for sin. Instead they were more likely to view labor pain in the context of redemption, joining with God, or in one case, a gracious blessing from God.

Sarah Anderson, a Catholic woman with a contemplative focus suggested a spiritual connection between experiencing pain and bringing life into the world. Anderson, who visited a monastery for silent meditation before each of her births, also saw suffering as redemptive. She ascribed a religious significance to pain in birth, but did not rely on the characterization given in Genesis 3.

> *MPW: Was there a significance to experiencing pain during birth?*
>
> *SA: I felt like I had come through something, that I helped it along or something. There was something about the intensity. Out of the intensity and out of that pain came this life.*
>
> *MPW: Did you think about being raised Catholic or being a Catholic? Did you think about the idea of pain during birth being the curse of Eve?*
>
> *SA: No, not at all. That wouldn't be what I . . . take pain with. No. As a Catholic I saw suffering or pain as redemptive, not as punishment. No. I felt it more like a joining of life. A joining [with] Christ, not separate. And also feeling that was a giving. Even when I was bedrest there was [a feeling of] "I can do anything. I can do this; I can give this for that, something so incredible." It was a small price. I would say that about the pain as well.*[17]

Anderson viewed her experiences of both bedrest and labor pain as a joining with Christ through a redemptive act of sacrifice, rather than as punishment. This is particularly interesting given the context of labor pain in Genesis 3: the expulsion of Adam and Eve from the Garden of Eden is often told as a story of the initial *separation* of God and man as a consequence of sin with pain as part of the punishment. Anderson viewed it instead

[17] Sarah Anderson [pseudo.], interview by author, audio recording, 12 November 2010.

as, "A joining . . . not separate." Penelope Hull, whose birth story I discuss in detail later, also described a relational element of pain quite vividly in her intimate and connected vision of Jesus during labor. She wrote, "He put my face to his chest, stroking my hair."

This recurring description of pain as facilitating a sense of connectedness is interesting considering several scholars have described isolation as an important feature in the experience of pain as negative trauma. Pain is often described as a deeply isolating experience, but some women describe this isolation from other people as an opportunity for connecting with the divine. Stevie Shalwater, for example, a young, non-denominational Christian, twins the experience of isolation and relationally by describing her experience of labor pain as, "like one year alone with God in prayer." In Shalwater's framework, the isolation from others that is experienced in pain heightened her experience of relationship with God. She said:

> *When a woman is in labor and giving birth — I call it labor land because you're just in a zone — you're in the moment and that can be spiritual because you're focused. I don't think I looked at it at the time as a spiritual moment. I don't know how to describe that. It's like one year alone with God and prayer, like if you're in an intense moment in prayer and thought, that kind of meditation. I could compare that to some parts of labor . . . Not at the beginning, not when you're actually able to talk, have a conversation; but towards the end when you cannot talk just because you're focused on getting that baby out and doing it well. And you're listening to encouragement from your midwife or your husband or whoever's there; you can hear them talking but you're just in the zone. And it's kind of like when you're praying or meditating—you're focused and you're in a zone but you're listening for the Holy Spirit . . . you're listening for encouraging thoughts or words . . . .*
>
> *I just always told myself you have to go through pain to get something good in life; not physical pain [necessarily] but it's always hard, you always go through a rough spot at times. [There are] peaks and valleys, but everything ends up turning out well. I think that why we sometimes fear that our bodies are made to do.*[18]

[18] Stevie Shalwater [pseudo.], interview by author, audio recording, 18 March 2010.

In terms of interpreting labor pain as spiritually or religiously significant in a positive way, interviewees often returned to the idea of choosing pain as a critical aspect of religious experience. Mariah Rosen, a Jewish woman who was a former doula also emphasized the importance of choice in religiously interpreting labor pain. She talked about the negative aspects of Genesis 3, and the importance of choice in interpreting labor pain positively. Rosen now works with Jewish students at the local University Hillel and is from a family of midwives and doulas. As a Jewish woman, she describes the impact of the Eden story on pregnancy and birth:

> *There is a religion significance [to labor pain] that I think is part of the problem. From the earliest age whether you go to religious school or not you learn a story about Adam and Eve and pain associated with childbirth. I think that that's one of the things that causes this innate fear in women, that they deserve this somehow or that that's how it has to be because that's how . . . if they're religious because God said so, or because the stories, not just from there, but then all the stories that are perpetuated from that one, at least in our culture [describe labor pain as a punishment.]*[19]

For Miller, the Genesis story evoked a possibility for drawing closer to God through suffering. She said:

> *I think of scripture when He talks about after Adam and Eve sinned. Talking about them, and then we'll toil and work, and women will have pain in their births. I think of that. I think for me . . . there is something significant that although it is so excruciating . . . that God gives us the ability to get through that. There's this proof in it. I think if it was just easy . . . I think it's like in life: Some of our hardest moments are what really shape up and bring us closer to the Lord. If all life was just easy I don't think we would be turning to him as much. I know in some of my hardest moments I've grown closer to him and more — I'm so far from how I'm supposed to be — how God wants me to be through those hard moments. And I think the birthing experience, it wouldn't be as sacred.*

[19] Mariah Rosen [pseudo.], interview by author, audio recording, 12 November 2010.

The amazingly broad potential for moral bricolage in the Eden story was perhaps most evocative in Miller's description of her birth experience:

> *It's just such a miracle. I don't know how one couldn't believe in God when you experience that, just what your body's able to do: it's just absolutely mind-blowing. And I think, too, the fact that I was able to do it without medicine to me is even more a testament — not about me, it has nothing to do with me — just the testament that we were created so beautifully and perfectly that you can do that. I mean it's a terrible pain but literally it was gone. That pain was still there but the intense feeling of it was just gone, when you see this beauty and this total miracle come out; you forget. And I could do it again. And that to me is what's so awesome; is that I would be willing. And it was terrible, it was the worst pain, but I could do it again in a heartbeat. There is just something so miraculous . . . . I'm thankful that God allows humans to come into the earth this way because he didn't have to do that, you know? It could be any way that he wanted. There's something so evident of his love. There's just a purpose. There's something in the way that he did that. Because we're sinners. There's just something so gracious that He allowed us to do that.*

For Miller, pain during birth is transformed from the traditional interpretation as a punishment for sin into a testament to the perfection and beauty of the created woman's body. "We were created so beautifully and perfectly that you can do that." In Miller's experience, unmedicated birth is a gift that a benevolent God bestows on unworthy sinners: "There's just something so *gracious* that He *allowed* us to do that." Her embodied knowledge of the religious significance of labor and birth takes precedence over the traditional interpretation of the biblical narrative transforming a curse into a blessing.

PENELOPE HULL: RE-CONTEXTUALIZING THE PSALMS

> *"This love felt so real during the suffering, it was so tangible to me that now when I pray I feel like Jesus and I have* been through *things together. I can hardly doubt his love anymore"*
>
> –Penelope Hull

Penelope Hull is an evangelical Christian in her thirties. Hull has four children. I interviewed her shortly after the birth of her fourth baby, but in this section I want to focus on the birth story from her third child, Jacob, which she recorded on a personal weblog.[20]

Among biblical spiritual narratives, those that directly address labor, Genesis 3 for example, tend to have negative associations. As an Evangelical, Hull relies fastidiously on biblical text as her major source of spiritual and religious insight. Though the majority of biblical narratives do not directly address the process of labor, Hull is able to create a moving spiritual narrative of labor in a Christian context by reinterpreting biblical passages that do not address childbirth directly. By moving biblical text from its original (often masculine) contexts, and putting it in direct conversation with her birth story, she liberates the narrative, allowing it to speak powerfully and directly to the embodied, female process of birth.

Written birth narratives are particularly interesting in terms of contextualizing birth within the framework of a traditional religious system. Recall that David Yamane argues that religious experience can only be understood post-facto in its narrative form since it is through the construction of stories that people make religious meaning of life events. According to Yamane, phenomenological elements of a religious experience only begin to make sense from a religious perspective once they can be narrated.[21] Yamane's argument was confirmed at many points during my interview process. For example, Meredith Marshall, the young Christian woman from Chapter 5 who transferred from a

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[20] Penelope Hull [pseudo.], interview by author, audio recording, 5 November 2010.
[21] David Yamane, "Narrative and Religious Experience," *Sociology of Religion* 61, no. 2 (Summer): 171-189.

birth center to the hospital after a "traumatic and surreal" 40-hour labor, emphasized the importance of her renewed relationship with her mother to her spiritual experience of birth. Though at the time she was focused on the intense sensation of pain, she repeatedly said that the relational aspects of her birth as a spiritual experience only became apparent, "in retrospect." Similarly Eva Jacobs, a reformed Jewish woman in her early thirties, whose birth story of a still birth is discussed in detail in my conclusion, described how the sheer physicality of birth makes its religious and spiritual aspects difficult to articulate until afterwards:

> *When you're in the birth you're just so in the birth; you're so in the moment. It's not until you're processing it . . . I'm about to go do this, or you're processing, "Wow, I've just done that!" that those metaphors of religion and spirituality . . . are really useful.*[22]

The process of narrative integration that Jacobs describes is particularly profound in the written narratives I was given. Even more so than in the oral narrating of a birth story, writing a birth story gives mothers the opportunity to very intentionally choose metaphors and frames that imbue the experience with spiritual and religious meaning.

Hull's birth story is an example of this phenomenon. (As is Jacob's, which takes the form of a finely honed five-part poem I will discuss in detail later.) By using specifically selected bible verses to frame the events of her labor and delivery, Hull's written birth story literally and metaphorically puts her experience in the context of Christian scripture. Hull's birth experience is also an excellent example of the need for spiritually and religiously accommodating hospital care. While she views birth as a profoundly religious experience, Hull also had several medical complications that made her a poor candidate for a home birth had she wanted one. She had a previous cesarean as

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[22] Eva Jacobs [pseudo.], interview by author, audio recording, 11 June 2010.

well as symptoms of pre-eclampsia when she entered the hospital, hoping for an unmedicated vaginal birth. She describes wanting a vaginal birth, but also acknowledging the importance of surrender to the will of God in her moving narrative. She writes:

> *"Arise, O Lord! Deliver me, O my God! . . . From the Lord comes deliverance, May your blessing be on your people" Psalm 3:7-8*
>
> Around 7 pm a resident came to check my cervix: 6-7cm and 80% effaced. I should have been encouraged by the progress but wasn't. I was expected to be fully effaced and near 10! I closed my eyes and descended . . . into suffering, into that alone place pain takes you. . . . I lay on my left side, gripping the rail of the bed and gritting my teeth . . . . Even people far from God use his Name when they get hurt, and at first I mumbled "Dear God" because I was surprised at the pain. Then I progressed to the place where I had to *call* on his Name to survive.
>
> *"She will call upon me; and I will answer her;*
> *I will be with her in trouble,*
> *I will deliver her and honor her." Psalm 91:15*
>
> I would endure one contraction and dread the next. I pictured Christ "the God of all comfort" on the cross; his eyes would meet mine and he'd nod, fully acquainted with suffering. *"Christ suffered in his body, so arm yourself with the same attitude, because whoever has suffered in their body is done with sin." 1 Peter 4:1* I shook my head no thinking, "No, I can't live through this again, not another contraction . . . " but these verses would pull me into relation with Christ himself. *"Don't be surprised at the painful trial you are suffering, as though something strange is happening to you. But rejoice that you participate in the sufferings of Christ, so you may be overjoyed when his glory is revealed." 1 Peter 4:12-13* With my eyes closed I saw Jesus walk over to me and take my hand, *"For I am the Lord, your God, who takes hold of your right hand and says to you, Do not fear, I will help you." Isaiah 41:13* Then he put my face to his chest, stroking my hair. *"He gathers the lambs in his arms, and carries them close to his heart." Isaiah 40:11* This love felt so real during the suffering, it was so tangible to me that now when I pray I feel like Jesus and I have *been through* things together. I can hardly doubt his love anymore.
>
> I found out later that the resident came in the room around then, looked at me and assumed, "She's had the epidural now, right" because I looked so peaceful. That blows my mind because in my memory I was writhing and moaning in pain, with

> white knuckles and gnashing teeth. But apparently I was just laying quietly on my side, mumbling about Jesus.[23]

Hull's use of scriptural references to frame an experience and imbue it with religious significance ties it into a long historical tradition in Christianity. For example, the birth story is somewhat reminiscent of John Donne's famous chronicle of his terrible illness, *Devotions Upon Emergent Occasions*. Both narrate a physical, bodily experience of suffering, and both rely on scripture to repeatedly contextualize the experience of bodily pain and suffering within the larger biblical narrative. Comparing the two narratives is informative. Donne moves immediately to the Genesis 3 story in his first pages, acknowledging his suffering and the eventuality of death as a consequence of "the first sin."[24] He even articulates one of the specific punishments for man's disobedience in the garden, writing, "It was part of Adam's punishment, In the sweat of thy brows thou shalt eat thy bread."[25] Hull, by contrast, makes no reference whatsoever to Genesis 3, choosing to frame her birth instead predominantly with Psalms.

Her reliance on Psalms and Isaiah to frame her labor experience may seem unsurprising on first reading. But her choice of passages is complicated by the fact that, while scriptural references to the gender nonspecific suffering of sickness, and death are common, references to the (women only) suffering of labor pains are extremely rare. Aside from a difficult reference in Revelations, and several metaphoric passages that use labor pain to describe other kinds of suffering, Genesis 3 is the main source of biblical scripture that addresses labor pain directly. This means that, while Donne went directly to the scriptural passage on original sin despite having many other options available, Hull

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[23] Penelope Hull, personal correspondence, 2 November 2010.
[24] John Donne, *Devotions Upon Emergent Occasions and Death's Duel* (New York, NY: Cosimo, 2010), 8.
[25] Ibid., 13.

avoided it in favor of passages that were much less obviously relevant to labor or birth. As I will illustrate in detail, in their original contexts, many of the passages she chose actually address, not just the gender neutral experiences of suffering from pestilence, but even the hyper masculine experience of suffering in war. By removing them from their masculine, militaristic contexts, Hull allows these militaristic psalms to describe the ultimately uplifting spiritual experience of labor pain better than the condemning passage from Genesis describes it.

For Hull, biblical text is central to religiously understanding life experience. But despite the Bible's condemning description of labor pain as a punishment for original sin, Hull is able to render her individual experience of labor pain as a positive experience that connected her personally with the suffering of Christ. She writes, "With my eyes closed I saw Jesus walk over to me and take my hand." Far from being unable to sacralize her experience of birth because of a strict attachment to the biblical texts of Western monotheism, Hull's religious narrative facilitated a visionary experience during birth.

Hull's birth story is an excellent example of the phenomenon Sered describes, whereby women, even in patriarchal cultures are actively involved in the creation and adaptation of religious rituals and symbols to describe their experiential knowledge. Since Hull identifies as an Evangelical Christian, her religious background, in which reliance on biblical texts is paramount, means that an approach like that suggested by Carol Christ—rejecting patriarchal monotheism in favor of Goddess-centered spirituality—would be inappropriate, even heretical. Rather than drawing on pre-modern Goddess traditions that directly spiritualize women's bodies, Hull uses the masculine narratives found in the Old Testament to sacralize the feminine experience of birth. And rather than referencing any of the specifically birth oriented biblical texts, Hull instead

draws on diverse texts that describe masculine experiences. Looking specifically at the first three verses she chooses is instructive.

The first verse Hull chooses to open her birth story is a selection from Psalm 3. It reads, *"Arise, O Lord! Deliver me, O my God! . . . From the Lord comes deliverance, May your blessing be on your people."* She then describes an extremely difficult moment in labor when the resident physician performs a cervical exam, and she has progressed much less than expected. In the context of her birth story, the selection seems perfectly germane to the experience of labor, unremarkable from the perspective of adapting or "procreating" religion. However, Psalm 3 is a text that, in its original context, describes the hyper-masculine experience of war. The Psalm, subtitled, "*A psalm of David. When he fled from his son Absalom,"* is a highly evocative and emotional description the experience of King David as he is forced out of Jerusalem by a group of soldiers led by his own mutinous son, Absalom.[26] The psalm begins, *"O Lord, how many are my foes! How many rise up against me! Many are saying of me, 'God will not deliver him.'"*

The text that Hull quotes for her birth story is from the final lines of the psalm. Uninterrupted, they read:

> *"I will not fear the tens of thousands drawn up against me on every side. Arise, O* Lord! *Deliver me, O my God! Strike all my enemies on the jaw; break the teeth of the wicked. From the* Lord *comes deliverance. May your blessing be on your people.*[27]

Compare the full text with Hull's selection:

> *"Arise, O Lord! Deliver me, O my God! . . . From the Lord comes deliverance, May your blessing be on your people"*

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[26] James Maxwell Miller and John Haralson Hayes, *A History of Ancient Israel and Judah* (Louisville, KY: Westminster John Knox Press, 1986), 175-177.
[27] Psalm 3: 6-8, NIV.

In the first rendering, the psalm does not seem germane to the experience of labor and birth. But by removing the overtly militaristic context in the line *"tens of thousands drawn against me on every side,"* and the violence of the psalmist's cry for just vengeance, *"strike all my enemies on the jaw; break the teeth of the wicked,"* Hull uses a description of the highly *masculine* experience of war to lend religious significance to the distinctly *feminine* experience of childbirth. By divorcing the lines she selects from their military context, Hull is even able to effectively pun on the phrase, "*Deliver* me, O my God!" thereby making Psalm 3 a passage about battle, far more relevant to her birth experience than a passage like Genesis 3, which addresses labor pains directly.

The idea that a passage about battle would be useful for describing religiosity or spirituality in a birth experience may seem surprising, but Hull is not alone in this kind of comparison. Midwife, Margaret Heinley, for example, described childbirth as "women's war," saying:

> *It's like people going to war, and discovering that they can do things—and I'm not talking about the bad things, like shooting people, I'm talking about looking after each other, and slogging through mud, being deprived of sleep. And [experiencing] hunger, and [learning to] just keep going because of the will to live. Childbirth is kind of like war, or battle. I don't like to think about it like a fight, but . . . I think women can find their strength.*[28]

Heinley's statement describes the kind of textual work that Hull is doing. Notice how Heinley struggles to make the comparison between battle and birth, resolving that, by removing the more antagonistic aspects, "the bad things, like shooting people," the metaphor is quite relevant.

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[28] Margaret Heinley [pseudo.], interview by author, audio recording, 12 May 2010.

Hull's use of Psalm 91 is similarly interesting. Psalm 91, partially reproduced below,[29] is arguably a less surprising choice for evoking during a birth. First, though it does rely on military metaphors, it lacks the overtly militaristic context of Psalm 3, addressing instead the less gendered experience of pestilence and plague. Second, it juxtaposes the traditionally masculine imagery of the lord as *"refuge and fortress . . . shield and rampart,"* [30] with the feminine imagery of God as a mother bird who *"will cover you with his feathers, and under his wings you will find refuge."*[31] Still, Hull has done some interesting textual work to make this biblical passage relevant to her own experience.

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[29] **1** Whoever dwells in the shelter of the Most High
will rest in the shadow of the Almighty.
2 I will say of the LORD, "He is my refuge and my fortress,
my God, in whom I trust."
3 Surely he will save you
from the fowler's snare
and from the deadly pestilence.
4 He will cover you with his feathers, ,
and under his wings you will find refuge;
his faithfulness will be your shield and rampart.
5 You will not fear the terror of night,
nor the arrow that flies by day,
6 nor the pestilence that stalks in the darkness,
nor the plague that destroys at midday.
7 A thousand may fall at your side,
ten thousand at your right hand,
but it will not come near you.
8 You will only observe with your eyes
and see the punishment of the wicked.

14 "Because he loves me," says the LORD, "I will rescue him;
I will protect him, for he acknowledges my name.
15 He will call on me, and I will answer him;
I will be with him in trouble,
I will deliver him and honor him.
16 With long life I will satisfy him
and show him my salvation."

[30] Psalm 91:2,4, NIV.
[31] Psalm 91:4, NIV.

Perhaps the most striking aspect of Hull's adaptation of the psalm for the purposes of describing labor pains, is that she has changed the pronoun "he," to "she." The original text reads:

> He will call on me, and I will answer him;
> I will be with him in trouble,
> I will deliver him and honor him.[32]

In her birth story, Hull renders the passage thusly:

> *She will call upon me; and I will answer her;*
> *I will be with her in trouble,*
> *I will deliver her and honor her.*

By substituting the feminine pronoun, *she*, Hull is again able to effectively make a pun with the word *deliver,* writing, "*I will deliver her and honor her*." Indeed, in the context of the birth story, and with the feminine pronoun, on first reading the passage seems to be written about a birth.

Furthermore, Hull's personalization of the verse with the feminine pronoun also evokes the "woman" most commonly referenced by Psalmists: Israel or Zion, the Jewish nation. While the Psalms generally use the pronoun *he* to refer to individuals, *she* appears commonly when the Psalms describe the Jewish nation. In the context of her birth story, Hull's use of the verse to refer to herself, a literal woman, evokes a fascinating reversal of the common use of a woman's body as a symbolic tool in the formation and reproduction of a national identity.[33] Biblically, women often represent nation, labor pains appear metaphorically as a stand in for national or individual male suffering, and the metaphor

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[32] Psalm 91: 14-15.

[33] For an excellent analysis of the interactions between women's literal and metaphoric bodies and the state, see Veena Das, "Language and Body: Transactions in the Construction of Pain," *Daedalus,* no. 125 (1996).

of spiritual rebirth takes priority over the bodily process of birth. But in Hull's birth story, the metaphoric woman, Israel, whom God will rescue, protect, and honor, is transformed a literal woman, crying out for redemption during a literal birth.

The selection from Isaiah 41, a chapter in which God addresses the nation of Israel, promising a military success, reinforces this idea. Again, the context of the verse she chooses is clearly militaristic. In context, the verse reads:

> All who rage against you
> will surely be ashamed and disgraced;
> those who oppose you
> will be as nothing and perish.
> **12** Though you search for your enemies,
> you will not find them.
> Those who wage war against you
> will be as nothing at all.
> ***13*** *For I am the LORD your God*
> *who takes hold of your right hand*
> *and says to you, Do not fear;*
> *I will help you.*

Hull chooses Verse 13 to frame her birth story:

> *"For I am the Lord, your God, who takes hold of your right hand and says to you, Do not fear, I will help you"*

Once again, Hull uses a passage that is directly oriented towards a military context, divorces it from its antagonistic elements and military imagery, and uses it to evoke a gentle, feminine image, this time of Christ, "the God of all comfort," in a maternal or even erotic image. She writes, "Then he put my face to his chest, stroking my hair."

Stout has described this process of re-contextualizing and repurposing moral language as "moral bricolage."[34] Stout describes the impossibility of attempting to adopt religiously neutral language (what he describes as "moral Esperanto") to talk about contemporary moral issues. Instead he suggests "moral bricolage" as an alternative by which extant moral languages, with their rich narratives and traditions, can be made applicable to moral debate in contemporary pluralistic societies. There is a parallel here with scholars like Carol Christ, who favor jettisoning patriarchal religious language completely when attempting to describe feminine spirituality, especially where issues of female sexuality or reproduction are concerned. Christ, of course, is doing her own sort of moral bricolage by drawing on pre-modern Goddess traditions. But the narrative and textual elements of these traditions are not accessible to all women. Hull is an excellent example of someone for whom the metaphors of Goddess-centered spirituality are likely not to be particularly helpful. Attempting to completely abandon the Abrahamic religious traditions as hopelessly entrenched in patriarchy neglects many American women, the majority of whom identify with some form of Christianity.

Hull's birth story shows another trajectory, by which a traditionally patriarchal religious narrative tradition can be sensitively applied to elevate feminine spirituality. A reader who questions the reasonability of Hull's textual work, divorcing religious imagery from its military or nationalistic context, should remember that the entire Christian religion is based on such a premise: the very idea of Jesus as the Jewish messiah was seen by many as problematic since the Jewish messiah was supposed to be a military leader. The prophecy, particularly in Isaiah, that Jesus fulfills seemed to predict a

[34] Jeffrey Stout, *Ethics After Babel: The Languages of Morals and Their Discontents* (Princeton, NJ: Princeton University Press, 2001), 74.

military leader who would unite nations and reinstate Jewish political domination. The idea that Jesus, a carpenter's son who was crucified in his mid twenties, represented a fulfillment of such prophecy necessitated an ability to recontextualize the military imagery of the prophetic books. This was one of Paul's great accomplishments as a moral bricoleur, but he did not do it without difficulty. In fact, Christian unfettering of messianic prophecy from its military context presented a challenge in converting Jews and Greeks alike. Paul suggests this in his correspondence with the church at Corinth, writing: "Jews demand signs and Greeks look for wisdom, but we preach Christ crucified: a stumbling block to Jews and foolishness to Gentiles."[35] The stumbling block that Paul suggests is the idea that the books of the prophets suggest the messiah as a military figure that will reunite Israel but instead manifests as "a crucified Messiah."

As Stout writes, great moral thinkers have always engaged in acts of moral bricolage. For women like Penelope Hull sacralizing an experience necessitates contextualizing it within a biblical framework. Moral bricolage can help square the positive spiritual experience of the embodied, feminine experience of birth with the condemning treatment it receives in Genesis.

I would like to close with an excerpt from my conversation with Mariah Rosen. When I asked her about her understanding of Genesis 3, she emphasized the importance of interpretive experience, using the Garden of Eden as a metaphor for the power of narrative interpretation.

> *MPW: What is the significance of that story for you?*
>
> *MR: I think that it's about choice, that suffering is optional, that you get to say how you're going to experience whatever circumstances are facing you at that time, and that that has to come authentically. That's got to be your truth: it can't*

[35] 1 Corinthians 1: 22-23, NIV.

> *come from somebody else declaring something on your behalf. The Garden of Eden, or birth, all of that, is really an internal experience. It's not something else. It's not something outside of yourself. You get to create your Garden of Eden, your birth experience; but you have to choose that.* [36]

Rosen emphasizes the elements of choice, involvement in the creative process, and personal authenticity as critical aspects of experiencing labor pain as positive. "You get to create your Garden of Eden, your birth experience; but you have to choose that." For Rosen, the Garden of Eden story, a narrative that has long been used to condemn women's bodies as irredeemably sinful, becomes a metaphor for the creative interpretive potential inherent in women's birth experience.

[36] Mariah Rosen [pseudo.], interview by author, audio recording, 12 November 2010.

Chapter 7:

Infant Death, Grief, and Childbirth as an Encounter with the *Mysterium Tremendum*

> *When a woman has had a miscarriage, when she has allowed her blood to flow, and has hidden the child, it is enough to cause the burning winds to blow and to parch the country with heat. The rain no longer falls, for the country is not longer in order. When the rain approaches the place where the blood is, it will not dare to approach. It will fear and remain at a distance.*
>
> -From a description of birth practices among the Bribri Indians in James Frazer's, *The Golden Bough, 1915.*

> *her wounds came from the same source as her power.*
>
> -Adrianne Riche, *"Power,"* from *The Dream of a Common Language,* 1978.

Of all the narratives I encountered in my study, one stands out in its ability to encompass the broad spectrum of numinous experience in birth. The narrative, by Eva Jacobs, a lawyer in her earlier thirties who gave birth in a hospital to a stillborn baby girl, takes the form of a five-part poem called, "The Grief Cycle." [Appendix B] By turns powerful, evocative, tragic, and empowering, the poem recounts Jacobs' experience of stillbirth, grief, and recovery. Jacobs, who now has a two-year-old son, Adam, born at home with a midwife, described her experience:

> *The hospital birth story is the story of the stillbirth and it's probably perfect for this [your project]. We knew ahead of time that the baby had died. We found out on Friday and we were scheduled to go to the hospital on Monday. . . . We had planned on having a home birth and our midwife became our doula and graciously came with us to the hospital. . . . . So what can I say? It was terrible. I*

> *mean there's probably no way to go into that experience without it being terrible, but it was just pretty terrible.*[1]

Jacobs summarizes her first birth experience with the stark sentence, "It was terrible," a term she repeats twice. Jacobs uses the word *terrible* in its colloquial sense, to describe something very bad. But the word is a provocative choice, considering its origins. From the Latin word, *terrēre,* meaning "to frighten," to be terrible means to be capable of "exciting great fear . . . dread or awe."[2] Like its synonyms, *awful* and *tremendous*, *terrible* is often used hyperbolically in contemporary contexts to describe ordinary events or objects that are simply very bad. In the context of spiritual experience, however, these words evoke a very different idea: they reflect the fear and trembling evoked by an encounter with the numinous. The German theologian Rudolph Otto describes this connection between the divine and the terrible in his discussion of Hebrew term *hiqdish,* which means, "to hallow." Otto writes that, "'To keep a thing holy in the heart' means to mark it off by a feeling of peculiar dread . . . [and] to appraise it by the category of the numinous."[3]

In his influential book, *The Idea of the Holy,* Otto describes numinous experience in terms of the *mysterium tremendum et fascinans,* the mystery that evokes fear and trembling, and at the same time fascinates and compels. Many of the birth stories and clinical tales I have discussed in this dissertation describe powerful experiences of the numinous, but most describe its positive aspects, what Otto calls the *mysterium fascinans*. These birth stories, and clinical tales contextualize the miraculous nature of female

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[1] Eva Jacobs [pseudo.], interview by author, audio recording, 11 June 2010.

[2] *The Oxford English Dictionary*, 3d ed., August 2010; online version November 2010, s.v. "terrible, awful, tremendous," (Accessed March 27, 2011).

[3] Rudolf Otto, *The Idea of the Holy: An Inquiry into the Non-Rational Factor in the Idea of the Divine and Its Relation to the Rational, 1923*, trans. John Harvey, 2nd ed. (London, UK: Oxford University Press, 1958), 13.

embodiment, lactation, gestation, and birth, in terms of their ability to evoke wonder and connectedness. Although they are generally far more expressive of spiritual experience than clinical narratives, birth stories nevertheless tend to be restrictive in their descriptions the awful power of birth. Particularly in home birth communities, where reading positive and empowering birth stories is seen as an important part of preparing mentally and emotionally for a "normal birth," birth stories with spiritual content tend to focus squarely on the *mysterium fascinans*. They rarely dwell for long on the more frightening idea of birth as an encounter with the *mysterium tremendum*. Penelope Hull's beautiful narrative of a visionary experience during labor, for example, narrates a physical and emotional encounter with God experienced through the trials of labor pain. But even though her narrative includes descriptions of suffering, it is ultimately a story of comfort, redemption, and salvation through pain. Her selective use of the Psalms, for example, removes many of their visceral and violent elements.

A desire to sterilize birth of the darker aspects of its sacral power is apparent in many narratives of birth from clinical, religious, and birth-activism oriented sources. In medical narratives of infant death, for example, technical terms like "intrauterine fetal demise," rather than *stillbirth,* and the avoidance of affective or metaphorical language, allow a clinical distance from death. Medical practice in general has been characterized as "man's adjustment to the *tremendum*."[4] Medicine mediates between humans and the disquieting recognition of bodily vulnerability in part by sanitizing narratives of their more disturbing affective dimensions. In religious narratives from Western monotheism, this sterilizing process takes the form of a removal of the animal, bodily, and sexual

[4] Daniel S. Goldberg, "Religion, the Culture of Biomedicine, and the Tremendum: Towards a Non-Essentialist Analysis of Interconnection," *Journal of Religion and Health* 46, no. 1 (2006): 99-108.

elements of birth. Christian narratives in particular are plagued by a discomfort with the animal or bodily elements of God. As I outlined in Chapter 2, this tendency manifests itself forcefully in an avoidance of the disquieting aspects of female embodiment. Affective descriptions of childbirth are particularly avoided. Birth is a painful, beautiful, bloody, and embodied event, and one that undeniably points to female sexuality. Historically, the Christian desire to sanitize God from the stigma and shame of female embodiment is best exemplified by the Church Fathers' insistence on describing Jesus' Nativity as a sanitized miracle whereby the infant Christ miraculously transmuted out of the Virgin womb, leaving Mary's hymen intact.

The potential to narrate an experience of birth as an encounter with the *tremendum* demands flexible narrative forms. For example, the visceral nature of the Nativity, and its connection with death has been elaborated on. Poetry is a particularly effective genre for expressing the sacral elements of birth. Yeats, in his poem, "The Magi," refers to the Nativity of Jesus as, "The uncontrollable mystery on the bestial floor." T.S. Eliot, similarly, in his "Journey of the Magi," makes the connection between the Nativity and death, writing:

> were we led all that way for
> Birth or Death? There was a Birth, certainly,
> We had evidence and no doubt. I had seen birth and death,
> But had thought they were different; this Birth was
> Hard and bitter agony for us, like Death, our death.

Both Yeats and Eliot create effective descriptions of the Nativity as an encounter with the *mysterium tremendum*. But to do so creates an uncomfortable tension with the narrative as it is typically rendered.

Otto writes of the *tremendum:*

> The feeling of it may at times come sweeping like a gentle tide, pervading the mind with a tranquil mood of deepest worship. It may pass over into a more set

> and lasting attitude of the soul, continuing, as it were, thrillingly vibrant and resonant . . . It may burst in sudden eruption up from the depths of the soul with spasms and convulsions, or lead to the strangest excitements, to intoxicated frenzy, to transport, and to ecstasy. It has its wild and demonic forms and can sink into an almost grisly horror and shuddering. It has its crude, barbaric antecedents and early manifestations, and again it may be developed into something beautiful and pure and glorious.[5]

Otto describes the extreme variation that characterizes spiritual experience, the emotional valence of which can range from tranquility, to excited frenzy, to grisly horror and shuddering, and back again.

Feminist thealogian, Melissa Raphael has suggested that the sacral power of female embodiment lies, at least in part, with its transformative potential. The generative power of reproduction suggests the idea of mutability within the female body: The matrix of the womb is a transformative space where new life is mysteriously shaped and transmuted. Similarly, woman's reproductive capacity suggests a transformative potential for the female body itself. Raphael describes, for example, "the female body's sacral capacity to become food for babies in the womb."[6] Similarly, she argues that the transition of breast tissue from the pre-pregnant state to lactation suggests a transformative sacral power inherent in women's embodiment.[7]

Many of the women I interviewed expressed wonder and awe at the miraculous nature of these transformative processes, but most did so by making reference to the perfect design of the creator, or, in more secular terms, the idea that their bodies were made to give birth. Meredith Marshall, for example, described a feeling that pregnancy

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[5] Otto, *The idea of the holy*, 12-13.
[6] Melissa Raphael, *Thealogy and Embodiment: The Post-Patriarchal Reconstruction of Female Sacrality* (New York, NY: Continuum International Publishing Group, 1996), 109.
[7] Ibid.

allowed women to "see God," through an experience of their bodies as "designed to work." She described:

> *It's designed to work, it's designed to! You're designed to nourish the baby from before the baby is even a baby and then all the way through till the end. My one friend who is kind of an atheist, she was talking to me about this before I had [my daughter]. She said, "It's just amazing how every little thing all work, so that it's exactly how it needs to [be]." It's kind of like, how you look at nature and you can see God in that. If you can't see God in that, I almost feel like you're not looking close enough.*[8]

Christine Chandler Miller similarly described feeling "more in awe of God" after her pregnancy and birth. She described having her faith in the benevolence of the creation confirmed by the transformation that occurred during fetal development as well as by the birth itself, which was unmedicated and vaginal. Miller explained:

> *I think that I'm more in awe of God. I'm more just able to sit before him and say, "You are awesome." Just the whole process of carrying her. We would look at the pictures of what she was like in each stage. And the development, it is such a miracle to watch: to see her now, just to see how she's going from total, a blob, to staring at me to being able to almost walk and talk. And her little brain, I can just see her learning, and it is just such a miracle . . . . I really believed that God made my body to be able to do this . . . I felt like he allowed me to have my body to do this. It's just such a miracle. I don't know how one couldn't believe in God when you experience that. Just what your body's able to do, it's just absolutely mind-blowing. And then I think, too, the fact that I was able to do it without medicine to me is even more a testament — not about me, it has nothing to do with me — just a testament that we were created so beautifully and perfectly that you can do that.*[9]

I have already described the tension that sometimes arises when women who have epidural anesthesia or cesarean section grapple with the implications of their bodies being out of line with a perception of what women were, "created to do," or "meant to do." With stillbirth or miscarriage, this idea becomes even more problematic. Far from

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[8] Meredith Marshall [pseudo.], interview by author, audio recording, 18 March 2010.
[9] Christine Chandler Miller [pseudo.], interview by author, audio recording, 22 March 2010.

reinforcing a belief that, as Miller suggests, "We were created so beautifully and perfectly," stillbirth has the reverse effect. It is a reification of the vulnerability and finitude of embodiment—an awful reminder that the transformative, sacral power of feminine embodiment carries with it not only the potential for life, but also for death, deformity, and disability. For the mother having a stillbirth, rather than the confirmation of a benevolent creator in the form of, "every little thing all work[ing] . . . exactly how it needs to," birth can provoke existential fear, despair, and grief. In short, it is an encounter with the *mysterium tremendum* in perhaps its most *terrible* form.

Though I encountered many descriptions in my interviews of stillbirth that were perceived as spiritually significant, most took the form of the redemptive narrative of stillbirth followed by a live birth. Physician Marti Anderson described:

> *I take care of women who have had horrible pregnancy outcomes. Who have had horrible things happen to them or their children, or their unborn children. And every birth is a miracle, but the overwhelming miracle of a live birth to a woman whose last baby was stillborn—I'm going to cry. It's like an angel has come into the room.*[10]

In the context of a subsequent live birth, the experience of stillbirth can be integrated into a story that involves struggle, but is ultimately about redemption. Arthur Frank might categorize these stories as restitution narratives, narratives where illness is represented as a transient misery after which life is restored to its previous state.[11] On the other hand, sacralizing an experience of stillbirth outside of the context of a subsequent live birth is a task that strains the limits of most

[10] Marti Anderson [pseudo.], interview by author, telephone, 15 June 2010.
[11] Arthur W. Frank, *The Wounded Storyteller: Body, Illness, and Ethics* (Chicago, IL: University Of Chicago Press, 1997).

narrative genres, including the birth story. This is part of what makes Jacobs' story so important.

Jacobs' "The Grief Cycle," grapples with stillbirth as an awful mystery that is nevertheless spiritually significant, not only in its psychological and emotional aspects, but also in its most visceral and embodied elements. Each of the five pieces in the cycle is named for one of Kubler-Ross five stages of grief. Even the title is an unsettling pairing of death with birth, since Kubler-Ross is perhaps most famous for her involvement in the creation of the hospice movement. By far the most diverse and daring birth story I encountered in terms of moral bricolage, Jacobs' "Grief Cycle" illustrates the potential for novel narrative genres that sacralize both positive and negative aspects of feminine embodiment. Faced with the task of coming to terms with the tragic and existentially traumatizing experience of stillbirth, Jacobs drew on myriad religious and secular sources. "The Grief Cycle" confronts the tragedy of stillbirth while simultaneously acknowledging that birth, even the birth of a dead baby, is a sacred experience. Jacobs' poem engages the female reproductive body in its full range, twinning descriptions of birth, menstruation, lactation, and sex, with the tragedy of premature death.

A self described, "atheist Jew," Jacobs draws on a varied metaphors, both secular and religious, and her poems are diverse in both form and content. She integrates diverse sources of spiritual and religious metaphor, and, though she certainly describes aspects of Judaism as an important source of comfort, Jacobs does not limit herself to Jewish, Abrahamic, or even religious metaphors.

Both the difficulty and importance of integrating birth into a religious and spiritual narrative framework is magnified in the case of stillbirth. Cross-culturally, stillbirth is highly stigmatized. Mentioned in Hoseah 9 as part of the punishment that God visits on Israel when her people begin to worship idols, stillbirth is sometimes

characterized as a divine punishment.[12] One of my interview subjects, Marcella Munos, for example, an Evangelical Christian from a working class family, lost her first baby. As a young, single mother, she had almost no prenatal care and did not receive the lethal diagnosis of anencephaly until she was at the hospital in active labor. For many years, Munos interpreted the birth as a punishment from God. Though years later she realized that idea was flawed and went on to have eleven children, Munos' experience illustrates the persistence of religious interpretations of stillbirth as divine punishment, even among contemporary women.

The stigmatization of the mothers of terminally ill babies is a common phenomenon with a long history. Postmodern philosopher Margrit Schildrick suggests that the stigmatization of the mother of a terminally ill child is a way to gain psychological distance from the baby. She calls this phenomenon, "othering the monster." The tendency to try and separate oneself from illness is a common phenomenon that extends to many types of illness. Stillbirth, or the birth of a terminally ill baby, is particularly troubling in several ways. In addition to provoking a fundamental question of theodicy, "Why must innocents suffer?" such a birth is also a frustration of the natural order of reproduction that gives order and meaning to life. Schildrick describes the fear and anxiety related to the birth of a baby with a lethal anomaly as, "The interior operation of the accidental that thwarts and limits sameness and repetition, that is the 'negation of the living by the nonviable."[13]

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[12] **14** Give them, LORD—
what will you give them?
Give them wombs that miscarry
and breasts that are dry. Hoseah 9:14, NIV

[13] Margrit Schildrick, *Embodying the Monster: Encounters With The Vulnerable Self,* (London: SAGE, 2002), 29.

The existential despair that can be evoked by a baby born to die is one of the most troubling themes in Samuel Becket's Existentialist masterpiece, *Waiting for Godot*. For Becket, a baby born dead comes to represent a distillation of the uselessness of life. Becket writes:

> Pozzo: (Suddenly furious) Have you not done tormenting me with your accursed time. It's abominable! When? When? One day, one day is that not enough for you? One day he went dumb, one day I went blind, one day he'll go deaf, one day we were born, one day we shall die, the same day, the same second. Is that not enough for you? They give birth astride a grave, the light gleams an instant, then it is night once more . . .
>
> Vladimir: Was I sleeping, while the others suffered? Am I sleeping now? Tomorrow, when I wake, or think I do, what shall I say of today? That with Estragon my friend, at this place, until the fall of night, I waited for Godot? That Pozzo passed, with his carrier, and that he spoke to us? Probably. But in all that what truth will there be (Vladimir looks at Estragon.) He'll know nothing. He'll tell me about the blows he received. (Pause.) Astride of a grave and a difficult birth. Down in the hole, lingeringly, the grave digger puts on the forceps.

Becket's troubling dialogue suggests the profound anxiety that surrounds the connection between birth and death. But the abstract despair provoked by the use of stillbirth as a bleak metaphor leaves little room for the possibility of interpreting such an event as an encounter with the *mysterium tremendum*. In fact, it forecloses the possibility for the integration of stillbirth into the narrative arc of a woman's life, and its potential to contribute to an understanding of women's reproductive power as sacred.

I spent considerable time in Chapter 6 describing the difficulty of integrating labor pain into a coherent religious narrative, but though labor pain is often characterized as a curse, the task of sacralizing it is eased by the fact that the pain is accompanied by the great joy of having a new baby. Women like Miller and Martin, who described feeling that their bodies were created by God to give birth in pain, can rely on the affirming embodied experience of holding a new baby to view their pain as a positive

aspect of the natural order. In the case of stillbirth, the difficulty of integrating a birth into a religious or spiritual framework is greatly compounded—rather than being an affirmation of the rightness of women's bodies before God, stillbirth seems to contravene the natural order. This means the narratives that women must create to integrate the experience of stillbirth into a coherent religious and spiritual framework will often be complicated and difficult to parse.

"The Grief Cycle" is no exception. It does not fit neatly into any specific category of religious interpretations of birth. In addition to exhibiting a great expressive range in terms of emotional and spiritual description, Jacobs' birth story is important as an example of the extreme diversity in emotional and spiritual description of embodied feminine experience. For Jacobs, the monotheistic tradition provides community and common morality, but she embraces Judaism without accepting the basic patriarchal tenant of a masculine God. She said:

> *I consider myself basically an atheist Jew—there's room in Judaism to be an atheist Jew, which people will debate . . . I don't know if I really believe in this, kind of, guy with a beard up in the clouds looking down, taking note of the world. I really just don't think He actually exists. But I like the value of a community of people who are dedicated to common morality marking life cycle events together. And even setting aside a time a week or every week to consider moral issues as opposed to material issues, consider things that are of a different quality of value.*[14]

Jacobs' ability to rely on Judaism as a source of strength and community during her painful experience, while at the same time rejecting the image of God as, "this kind of, guy with a beard up in the clouds looking down," allows her a great deal of flexibility in her construction of birth as a sacred embodied event. Partly because it neither restricts

[14] Eva Jacobs [pseudo.], interview by author, audio recording, 11 June 2010.

itself to monotheistic metaphors nor rejects them completely, "The Grief Cycle," reflects the extreme range of possibilities for sacralizing birth.

Through the use of poetic metaphor, Jacobs sacralizes an embodied feminine experience of birth that involves an encounter with both poles of the *mysterium tremendum et fascinans*. The first poem entitled, "Denial," beings:

> The tourists are easily fooled
> by piercing wails. The mood and brood
> that split easily between tears and inane laughter.
> The Tourists look for white capped waves,
> pounding surf and pain shifting like dunes.
> They are distracted by the drama.
> The show and tale.
>
> Those immigrants who dwell here
> know that this is a country of held breaths.
> Grief lives in the lungs, in the frozen swell
> of the chest. The dry breasts. Immobile,
> unmoving death hosts a quiet table after all, and
> silence is the soft, expensive spell
> that prevents our deportation,
> We aliens who linger.
> We, the bereft.

With its opening line, "The tourists are easily fooled . . . They are distracted by the drama," Jacobs describes the experience of stillbirth as an immigration to "a country of held breaths," where "silence is the soft, expensive spell that prevents our deportation." Jacobs evokes Susan Sontag's famous metaphor of Illness as a "kingdom" to which we all hold an "onerous citizenship." [15] Sontag distinguishes between the actual experience of the ill person, "what it is really like to emigrate to the kingdom of the ill and live there," and, the harmful stereotypes of that experience, "the punitive or sentimental

[15] Susan Sontag, *Illness as Metaphor and AIDS and Its Metaphors* (Picador, 2001), 3.

fantasies concocted about that situation," what she describes as, "not real geography, but stereotypes of national character."[16] Jacobs' opening poem, "Denial," hinges on this distinction, characterizing those on the outside of the grief experience as "tourists," eager for an exciting and dramatic show of grief. They, "look for white capped waves,/ pounding surf and pain shifting like dunes./They are distracted by the drama." The second stanza, which begins, "Those immigrants who dwell here know that this is a country of held breaths," contrasts the apparent dynamic drama of the tourist perspective with the reality of grief as fixed, still and silent. She writes: "Immobile, / unmoving death hosts a quiet table after all, and/ silence is the soft, expensive spell/that prevents our deportation."

Because of the fine line between pain and power, spiritual descriptions of women's embodied experience can sometimes seem paradoxical. Though "Denial" hinges on the distinction between the tourists, who are "easily fooled," and the grieving "immigrants," who experienced death personally, in her interview Jacobs also detailed the importance of being surrounded by a religious community after her birth. Though they may be "the tourists," in her opening poem, Jacobs described the importance of friends and family in the small, personalized religious ceremony she held after her stillbirth. She explained:

> *I'm Jewish. I am a practicing reformed Jew. I have been fairly involved in my congregation and I certainly turn to Judaism to mark lifecycle events, significant events in my life. Not that I keep kosher or any other of the other kind of daily things; it's a much more event-oriented religious experience for me. We had a ceremony; we had actually a lovely ceremony at my parents' house for the baby. It was . . . the service you do at the end of Shabbat — to say goodbye to the end of the Shabbat. We had it the week after the baby, after the birth. We had a couple of nice readings and we had the spice box and passed the candles and Rebecca sang*

[16] Susan Sontag, *Illness as Metaphor and AIDS and Its Metaphors* (Picador, 2001), 3.

> *a song, and a bunch of people came and we had a potluck and it was a very lovely little in-house event, small. [Our friend] Jennifer knew about it and sent a postcard, which is one of the things we read. She wrote us this beautiful postcard about winter in Chicago. And we read an Emily Dickenson poem about grief, and Rebecca sang "The Rose".*
>
> *James [my husband] didn't really get to grieve or start grieving until the community gathered, right? For him it was not safe to grieve until there was this community kind of outpouring of love and support. I mean that's what triggers him and clicks for him. I held it together really well at the event. I grieve less in public and more in private.*

Jacobs incorporated secular music, (the Rose), an Emily Dickenson poem, personal poetry written by close friends, and a potluck, into a traditional Jewish ceremony. She describes the ceremony being important to her husband, but also her need to "hold it together," and grieve in private."

While "Denial," describes the isolating experience of grief after the birth, the second poem in the cycle, "Anger," is a visceral, evocative description of the birth experience itself. Though religious ceremonies like the one Jacobs described above helped incorporate the birth into the context of a supportive community, the experience of the birth lends itself less well to overtly religious ritual, especially in the context of Abrahamic monotheism. Unlike most of the other birth stories I have referenced, "Anger" evokes the frightening, sensual, embodied and surprising elements of the birth experience. Particularly in its frank references to sexuality, "Anger" brings to mind some of Anne Sexton's work in its forceful, emotional and sexual descriptions of embodied female experience.

By turns determined, frenetic, cynical, wry, and erotic, "Anger" is a huge shift in tone from the quiet, reflective, "Denial." The emotional trajectory of the poem is dynamic, and its range extreme. Each of the poem's five stanzas begins with the line, "When I was giving birth to you," and each stanza shortens slightly, giving the poem a

feeling of quickening pace until the abrupt and bleak two line ending, "When I was giving birth to you, / you, who could never be born."

The poem begins forcefully:

> When I was giving birth to you
> I ordered my mother and the midwife to smile.
> This is still a birth I growled,
> no mourning till afterward.
> They were kneeling around me
> with their arms open in supplication.
> They were praying.
> They were holding me up.
> They were waiting for me to fall.
> My mother's face swam and bobbed, bloated with fear
> her wide eyes tracing the veins of your death
> under my skin. Laughter tricked down my cheeks
> as I looked at her.
> *Please come*, I said. *It's okay,*
> *we all want to meet you,* I lied.
> Your father and I presented a unified front.

The opening of the first stanza begins with a staunch, focused and angry determination, reading, "When I was giving birth to you/I *ordered* my mother and the midwife to smile. /This is still a birth I *growled*, /no mourning till afterward." Jacobs then moves through a serene description of her birth attendants, laden with traditional religious language. She writes: "They were kneeling around me/ with their arms open in supplication. They were praying."

Jacobs' use of traditional religious language is complicated by her description from our interview. She described:

> *More than anything else I wanted to move, I wanted to walk the hallways, I was doing squats, I was hanging on the back of chairs, I was being a monkey, I looked out every window, and bounced and rocked. I had a strong, strong desire to move. And my feeling during the whole time was the nurses were kept trying to put me*

> *back in my room, didn't want me walking the floor, kept trying to put me back in the room. And when they came in the room always like, "Don't you want to get on the bed"? And I'm like, "No! I really don't want to get on the bed." And I couldn't help thinking, "I'm getting away with more because they know the baby is dead and if the baby wasn't dead I wouldn't have been allowed to move as much as I wanted to move." . . . I was standing up, I was squatting, we were in the goddess position from prenatal Yoga and James was holding me up.*

In this context, it is Jacobs *as* the Goddess, rather than an external Abrahamic God, who is the focus of prayer, supplication, and attention. But rather than the kind of friendly, earth-mother often associated with the neo-pagan movement, Jacobs describes herself as frenzied and emotionally unstable, a frightening figure who laughs hysterically as her own mother traces "the veins of . . . death" under her skin. The reader senses some of the up and down rhythm of the "white capped waves," from "Denial," with the line, "They were holding me up. / They were waiting for me to fall." Then the tone shifts dramatically with the frenzied line, "Laughter tricked down my cheeks," which suggests crying and laughing simultaneously.

The second stanza describes these medical aspects of the birth:

> When I was giving birth to you
> the hospital nurses kept putting me back in bed.
> They inserted the drug to cause contractions
> into my cervix and told me to lie still.
> We watched movies and played cards.
> We told jokes and played the radio.
> Your father was talking about work.
> We told more jokes.
> One made you father laugh so hard that he excitedly
> started to explain the babysitting arrangement,
> the words expanding and clinging to him in a yellow fog.
> They ate through his skin
> and left the smell of ashes in his hair.
> He suffocated, right there in the hospital.

Jacobs described her induction in detail in our interview as well, but the narrative form of the birth story does not allow the affective description that the poem conveys. She described:

> *On the hospital level they'd obviously dealt with this before: They put white roses on the room so that people would know that the woman in there was having a stillbirth . . . The birth took forever. I don't know if it took forever; that's wrong. We checked in at like eight in the morning and I guess the baby was born at like four in the afternoon. But you know they lie you on the table and they stick the pitocin in and . . . you're going to have to lie there for two hours to make sure it sticks in the right place.*

In addition to describing the medical intervention, Jacobs also talked about the humor that pervaded the birth experience and the nursing care she perceived as intrusive and condescending. She said:

> *Like, I've got the dead baby birth. But we had a lot of black humor and we had a fair amount of levity in the room when it was going on among us. And at one point we actually all got kind of happy. Enough that James [started to explain our childcare plans, saying,] "Oh, and this what we're going to do once the baby is born, we're going to set up this room with [our friend] who's also pregnant and we're going to work on hiring someone" . . . and then he just had to stop in the middle of it because he'd totally just switched over to talking about how we were going to split a nanny with somebody, but you know of course we weren't going to split a nanny anymore.*
>
> *Now, the birth. Okay, so once the birth starting acting hot and heavy, right, I'm sitting there and I'm grunting and rocking and James is kind of holding me up and balancing me from the back and Susan and my mother are on either side. I've got this little circle around me as I'm grunting and rocking. And the nurse comes in and says, "Wouldn't you like to get in the bed?" And I'm like, "No, fuck it, I won't. I wouldn't, thank you, bye." And she's like, "Well, okay, but eventually you're going to have to get in the bed," and then she leaves and I go back to grunting and rocking.*
>
> *And the low point is when at some point I look and say to them, "I hate that bitch"—speaking about the nurse—which everybody in the room [thought was hilarious], like James, snorted. It was my low point. I was really angry but they thought it was hysterical.*

In the narrative genre of the birth story, Jacobs is able to explain the events that occurred, and attach some emotional significance to them. But in her poetic description, she heightens the bleak, despairing nature of the event by twinning the "black humor," with descriptions of stillness, stagnation, and even suffocation.

The third and fourth stanzas return to the theme from "Denial" of the stark contrast between the interior experience of stillbirth and the view from outside. Jacobs writes:

> When I was giving birth to you
> the midwife said "see the window opening;"
> "soft and open" she said.
> I threw my arms wide and moaned.
> I squatted and leaned on your father.
> He was a throne, an anchor, a windowsill.
> The midwife pulled her bloody hand
> from my cunt and said the cervix is tilted back
> "Think loose and forward," she said,
> "loose and forward, soft and open."
>
> When I was giving birth to you
> I saw you at the bar you would never sit at
> smoking the cigarettes that were too late to kill you.
> Pulling up your skirt and laughing with
> your tongue between your teeth.
> Come on you harlot, I said, you tease.
> Heartbreaker. Rebel. Live fast
> and die young. Come out, I thought,
> and show us your exquisite corpse.
>
> When I was giving birth to you,
> you, who could never be born.

This stanza describes the common midwifery practice of visualization during labor. Often midwives and doulas will suggest an image for a birthing woman to meditate on while she labors with the idea that the process will allow the woman to relax and engage,

psychologically facilitating cervical dilation. The image is often one of a flower opening: in this case it is a window ("the midwife said 'see the window opening;'/ 'soft and open' she said'). The image of the window creates a metaphor for a contrasting interior versus exterior view. The first half of the third stanza focuses on the exterior view. We are presented with an image of Jacobs in the hospital room, throwing "my arms wide" and moaning. Then the text dives inward, turning on the image of the open window, an object that offers a view from inside to outside, first to the inside of the body, with her graphic description of a cervical exam, and then to her own interior mental experience.

Finally, Jacobs immerses the reader in her interior experience. She takes the soft, relaxing visual of an airy window opening and, by juxtaposing it with visceral bodily imagery, makes it distressingly erotic. She writes: "The midwife pulled her bloody hand/ from my cunt and said the cervix is tilted back/ 'Think loose and forward,' she said, / 'loose and forward, soft and open.'" In the fourth stanza she puns on the midwife's suggestion, "Think loose and forward . . . soft and open," revealing an interior experience that is wildly different from what the midwife intends. Jacobs describes a striking vision of her daughter as, "a flirty girl at a nightclub in a red dress."

The stanza is heartbreaking, and shockingly evocative in its sexualization of the birth experience. Her characterization of the baby as a "tease," and "a heartbreaker," who will "die young," lends a frenetic element to the poem, eroticizing even the experience of grief by comparing it to a glamorized romantic heartbreak. The feeling of energy and sexuality give the couplet at the end an abrupt feeling, adding to the reader's shared experience of untimely ending and life abruptly cut short.

Despite the intense discomfort engendered by the description from "Anger," in our interview, Jacobs described the vision of her daughter in a nightclub as a very positive experience, and as the "high point" of her birth. She explained:

> *My high point was Meredith was telling me visualize soft and open, soft and open, and I all of a sudden have this image of the girl, of my daughter, my dead baby daughter, as like a flirty girl at a nightclub in a red dress, like, "soft and open," there she is. And I'm like, "Oh, look at that." That made me really happy. And I then ordered everybody else in the room that they had to smile, that this was still a birth and it was still happy which freaked the shit out of them. I didn't know afterwards but they were like, "Uh . . . huh?" But I enjoyed that moment.*

Jacob's vision of her daughter as "a flirty girl in a nightclub in a red dress," presents a sharp contrast to Penelope Hull's vision of Jesus during labor from Chapter 6. The differences and similarities between the two evince the extreme range of women's spirituality, even in the context of Abrahamic monotheism. There are some similarities between the two descriptions; for example, Hull's description of her vision of Jesus is somewhat erotic or at least romantic. But Jacobs' vision is unorthodox in its extreme sexuality.[17]

The fear and power engendered by "Anger," is a shocking departure from the ideal of sexual purity often encountered in descriptions of feminine spirituality in the monotheistic traditions. The sexual aggression in the terms *harlot, tease, rebel, and heartbreaker,* evoke an almost masculinized sexuality. Referencing yet another spiritual tradition, Jacobs, whose husband is a practitioner of Chinese medicine, suggested that birth, by nature includes highly masculine elements. She explained: "Birth is entirely *yang*. I don't know how else to describe it." Jacobs' suggestion that birth involves a projective, masculine energy, helps explain the relationship between childbirth and war

[17] "Bargaining," which I will only discuss briefly because it does not deal directly with embodied experience, is a short story in which the main character, Susan, a junior associate at a prestigious law firm, attends a luncheon for female lawyers after a doctor's appointment. Jacobs, who is a lawyer, details the difficulties of a partner-track lawyer in negotiating pregnancy and childrearing in the context of a successful career. The story plays on themes like the lack of female camaraderie in career-track women with the line, "Once, at a staff meeting, Bethany had said a trailblazer was just a 'machete wielding bitch.'" It creates a bleak sense of alienation and isolation and portrays a complete lack of space for discussions of embodied experience or vulnerability in the male-dominated profession. The title of the piece suggests the bargaining that any woman with a career must do in order to try to balance work and family, but also hints at the idea that Susan might exchange her career for a successful pregnancy.

that Heinley described, as well as the usefulness of the military metaphors for describing Hull's birth. But while both Heinley and Hull made sure to distance themselves from the angry, visceral, and violent elements of their masculine metaphors, Hull embraces the full spectrum of *yang* in her description.

One of the unique aspects of Jacobs' "Grief Cycle," is her boldness in twining sexuality with the other, more acceptable aspects of reproduction. In her critique of pornography, Raphael suggests that it is the inappropriate severing of sexuality from the sacral, transformative, and reproductive aspects of female embodiment that facilitates objectification.[18] In a related way, religious studies scholar Christina Traina maligns Christianity's discomfort with the connection between reproduction and sexuality.[19] Even feminist activism, both in its second and third-wave incarnations, has attempted to sever the ties between sex and reproduction: physically, with the liberation of women from perpetual childbearing, and rhetorically, in its insistence on conceiving of female sexual pleasure as independent from reproduction.[20] Jacobs' poem, which makes the link between reproduction and sex explicit, engenders a great deal of discomfort for the reader. This is particularly true in her fourth piece, "Depression," which ties sexuality with reproduction, lactation, and menstruation, and then goes a step further suggesting all these embodied experiences as closely tied with death.

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[18] Raphael, *Thealogy and Embodiment*.

[19] Cristina L. H. Traina, "Maternal Experience and the Boundaries of Christian Sexual Ethics," *Signs* 25, no. 2 (Winter): 369-405.

[20] These are clearly laudable gains. However, the tendency of contemporary feminists to sever issues of female sexuality from birth and reproduction can reach almost comical levels. For example, a recent call for papers to the *Journal of Women's History* for a special issue on sex and reproduction felt the need to include an explanatory description of exactly how the two are even related. It reads: "Although today some may think of 'sex' and 'reproduction' as unrelated topics and fields of research, historically they have been closely intertwined. Leslie J. Reagan, "CFP: Journal of Women's History: Reproduction, Sex, and Power." Accessed March 29, 2012. http://historyfeminism.wordpress.com/2008/04/30/cfp-journal-of-womens-history-reproduction-sex-and-power/

"Depression," is a frank and heartbreaking description of sex, lactation, and menstruation after a stillbirth. Jacobs describes the experience of menstruating on the baby's due date:

> Today is Monday and I have my period.
> Months ago they told me that labor pains
> were like menstrual pains, but more.
> The thighs pushing on the lower back,
> the lower back pulling on the abdomen,
> the abdomen squeezing the womb,
> the womb uncoiling its constrictions,
> until life floods into the world . . . .
>
> Saturday night his head was pressed to my bosom.
> He suckled at my breast and drew
> the hands of pain out of my chest,
> They filled his mouth with dry sobs
> that could not escape, the sadness climbed
> through my ears and out my mouth, until
> he touched my cheeks and I leaned
> against the distant reach of his hand
> opening my eyes to watch the darkness
> lap at his arm, soaking the pillows between us.
>
> Friday, was the due date. I realized this in the bathroom
> as I was putting away a fresh box of tampons.
> It has been long enough since you died for me to have three periods.
> They told me that labor pains were like menstrual pains, but more.
> At the hospital though, none of the polyester rose nurses, with
> their white rustling about anti-depressants
> and gentle determination to keep me in bed, mentioned
> that menstrual pains were like labor pains, but less.
>
> The thighs, the back, the abdomen, the womb—and life floods.

The poem also includes the poignant description: "My husband and I

lay in bed all morning. We made love/ with gentle determination." By detailing lactation, menstruation, and sex, Jacobs contrasts the persistence of life-giving bodily processes with the untimely death of her baby.

"The Grief Cycle" ends with "Acceptance," a first person essay in which Jacobs describes, "It is such a strange unrequited love, this passion I have for her. I didn't know her, there wasn't really any her to know." Like "Depression," and "Anger," "Acceptance" deals squarely with the visceral and embodied nature of reproduction. Jacobs compares death to both birth and sex, writing:

> Death is ethereal. A spark, a soul, a mystical animating force that was, is gone. It leaves the body. Dead is physical in a grimy, dirty, grand, and private way. Like sex. Or birth. Except that there is no one giving awkward, incomplete, inaccurate but earnest "this is what it's like to be dead stories." Only the body is left. It bears the marks. It is forever changed.

The stark triptych, "Only the body is left. It bears the marks. It is forever changed," points to the embodiment of birth and the relationship between generation and transformation. "Acceptance," ends with the overtly religious image of "an altar" to the baby that Jacobs builds, takes down, then builds again:

> My baby is dead. I take out the pictures. I put them up on the wall. I build an altar, take it down, and build it again. I want to show the pictures. I want to surprise myself with them. I want to frame them and just have them about. Like the refrain in my head, my baby is dead. I want everyone to see. She was here. She had a birth and a death. She had a body.

This final paragraph of "The Grief Cycle" is similar to the earlier passage suggesting both the ethereal and physical nature of death. "Acceptance," moves from the religious symbol of the built altar to the body itself, emphasizing the dual nature of female embodied experience as simultaneously transcendent and visceral.

Jacobs' "Grief Cycle," is a fascinating example of how a woman who identifies with a tradition of Abrahamic monotheism can spiritualize an experience that hinges on

one of the most terrifying and stigmatized aspect of female embodiment. It represents the broad potential for an understanding of spiritual and religious experience in birth that express birth as both an embodied sacral experience, and an encounter with the *mysterium tremendum et fascinans*.

Conclusions

This dissertation began by examining ways in which women's embodied spirituality is marginalized and stigmatized during childbirth. The medicalization and biologization of birth have contributed to an emphasis on the empirical and visible aspects of birth that leaves little room for narration of the spiritual, emotional, or religious. Similarly, the major Western religious systems of patriarchal monotheism have marginalized ritual practices that might convey childbirth as a positive religious event. Even aspects of the contemporary childbirth movements, when attended by a singular focus on home-birth or unmedicated birth, can work paradoxically to stigmatize and shame women who fail to conform to the sometimes rigid prescriptions of a what constitutes a good or natural birth.

Despite impediments from each of these three sources, women and maternity care providers continue to experience birth as a sacred, religious and spiritual, life-cycle event, and to articulate these experiences when they are given sympathetic narrative forms. Childbirth resists the desacralizing thrust of biologization; the experience of birth overshadows the stigma and shame associated with condemning biblical descriptions; and women and their providers find spiritual and religious meaning in births that in no way conform to the rigid constructs sometimes encountered in childbirth activism. Providers like intern Karina Neiman, who was emotionally sustained and spiritually nourished by a memory of the high-tech medical event, abdominal cerclage, still perceive birth as spiritually significant in the midst of highly medicalized hospital settings. Women like Penelope Hull, whose vision of Jesus sustained her during labor, identify with fundamentalist interpretations of patriarchal Western monotheistic traditions, yet

continue to experience birth as a positive gift, and a sacred event. And doulas like Jane Rogers, whose hospital transfer contravened her dreams of a natural home-birth, yet still felt "as if I had been baptized," persist in identifying the spiritually transformative potential of birth that deviates from the home-birth standard of "natural." In short, despite serious obstacles, birth continues to transform, elate, empower, and bring spiritual and religious meaning to birthing women and their maternity-care providers in hospital environments.

I have given a great deal of attention to the development and employment of narrative forms, pointing to the power of narrative to shape experience and define practice. Rigid narrative genres like the case history make the narration of birth as a spiritually significant life-cycle event difficult, therefore providers must resort to alternative narrative genres to describe their birth experiences as spiritually or religiously significant. Similarly, the narratives and metaphors available in patriarchal religious traditions like Christianity often marginalize and stigmatize embodied experience, particularly that of women. But these rigid narrative forms do not foreclose the possibility of experiencing or narrating hospital birth as a sacred event. Providers create to alternative genres like the clinical tale, and religious women use to acts of moral bricolage to describe their experiences of labor and childbirth as sacred events. Birthing women and their maternity care providers continue to participate in what Pamela Klassen has called, "procreating religion," in hospital environments, making religious and spiritual meaning out of the embodied, feminine experience of birth.[1]

[1] Pamela Klassen, *Blessed Events: Religion and Home Birth in America* (Princeton, NJ: Princeton University Press, 2001).

I mentioned in the introduction my belief that narrative is essential as a framework for virtuous clinical practice alongside my sincere hope that the stories examined in this project will be the beginning of a new narrative core by which patients and maternity care providers can contextualize hospital birth as a sacred event. The clinical tales and birth stories examined in this dissertation provide the beginning of such a framework. However, the birth story and the clinical tale are also genres with their own conventions, rules, and constraints. And though they provide a great deal more flexibility for describing childbirth experience as a sacral or life-cycle event, they nevertheless contain narrative constraints. While birth stories and clinical tales do a great deal to help illuminate the compelling aspects of birth, their conventions still tend to marginalize the terrifying aspects of the numinous. Birth is a messy, sexual, and bodily affair, replete with pain, sweat, amniotic fluid, even feces. It is also uncomfortably close to death. Though clinical tales and birth stories do allow their narrators some flexibility in being able to articulate these aspects of birth, aspects that are central to the sacral nature of women's embodied experience, for the most part they still marginalize the terrible, animal, and sexual nature of feminine spirituality as it manifests itself in birth.

The darker side of birth spirituality has also been marginalized by a discourse in birth advocacy circles that consistently hopes to reduce the perception of risk in birth. And while this is an important project in terms of acknowledging birth as a non-pathological life-cycle event, it also reduces the possibility for articulation of birth as an encounter with the *mysterium tremendum*. Fully articulating an experience of the numinous in childbirth necessitates acknowledging the unsavory connection of birth with sex and death, and of generative power with deformity.

I would like to end with a story from Sandra Anderson. Anderson is a contemplative Catholic with four children. Insightful and reflective, Anderson visited a

monastery for silent contemplation before each of her three births. She shared with me a description of an existential crisis the night before the birth of her fourth child, Michael. She became pregnant with Michael after miscarriage, but her story is not a typical restitution narrative of live birth after stillbirth. Rather, her story is a beautiful testament to the transformative potential inherent in an encounter with the *mysterium tremendum,* and the ability to radically reinterpret such an encounter through the experience of birth. Anderson described:

> *God . . . the night before his birth I had an existential crisis . . .*
>
> *I was upset that night. I was going in [to the hospital the next day to give birth.] It was a planned thing so we knew I was going in. I had the boys in the bathtub, [my daughter was] there, too, I had all three of them. I was tired, I was very pregnant, and [my husband] was going out to some birthday thing of somebody's or something. I was angry [about that, thinking], "You're leaving me with these guys. I'm really tired. I've got to do this [give birth] tomorrow." And by that time I knew what that meant. [Because I had given birth three times before]*
>
> *Something about that that triggered something.*
>
> *I remember being in the shower and it just came on me: it was just darkness. I don't even quite know how to put words to this, but it was as if the reality was there was only darkness. Not knowing if there even was a God—if there was anything else. That it was just darkness and that was it. Only that. Nothing else. And that after—other than this life—it was just that, for all eternity. And this feeling of, "God, and I'm bringing this child into this."*
>
> *It was a great unknowing but in a very despairing kind of way. Clearly it was coming; he was coming and it was just what it was . . . This all just opened up, like, "Oh my God! I don't know if there's a God, I don't if there's anything, just anything, just darkness." And the vastness of that. Look on the other side; nobody there. It's just aloneness . . .*
>
> *That was significant that that happened the night before his birth. And I see that in a very different way now. I don't see it as despairing, I see it in a different way. But at the time it definitely felt that way.*
>
> *So Michael, when he came it was about six . . . six-thirty-ish or maybe six-forty, right in there at dinnertime and I had an epidural for this one. I don't know why .*

. . Anyway I had an epidural so I couldn't necessarily feel but I think he was coming, he was crowning and the doctor wasn't there yet so I think they were kind of holding him back a little bit till the doctor got there. And then when he came there was a little bit of distress I think, and I think that the cord was wrapped I believe . . . there was a little distress thing happening; although when he was born he was fine, he was good. He was a happy baby, too . . . .

And Michael we always called an old soul as a baby. I always felt like changing his diapers or whatever that he was like this old guy; that he was putting up with it. He was just this amazing human being, and I don't know why. And he still is, kind of, an amazing guy in that way . . . .

MPW: How did the birth affect that existential despair?

SA: I'm not sure it did. That was in its own context and in its own. . . it was just an experience that came. It wasn't so much a thought, it was an experience . . . that just dropped away as I moved through the birthing and that's all there was . . . During that time I didn't know what that meant . . .

MPW: You said that you think of that experience differently now than you did at the time. Can you elaborate on that a little bit?

SA: I think inside other things have become apparent and that [now] I see that that vast darkness isn't despairing; I think it's that which everything comes out of. And I see that now as amazing, not despairing.

MPW: That's a really powerful metaphor for that to happen right before a birth.

SA: God, you know it is. Out of the darkness of the womb. God, I never thought about that. Well-placed, huh? However that happens.[2]

Anderson's description is of a dark night of the soul, a powerful encounter with the *mysterium tremendum* in which she recognizes a dark, and seemingly bleak abyss. But through the experience of birth, and through an integration of her existential despair into the arc of her life, Anderson reconceives that abyss as a generative matrix. And through the narration of her experience in our interview, she connected that matrix to the womb. Mercia Eliade similarly connects birth to death, suggesting the dying man's desire to

[2] Sandra Anderson [pseudo.], interview by author, audio recording, 12 November 2010.

return to the body of the earth is a representation of the, "fundamental experience—that the human mother is only the representative of the telluric Great Mother."[3]

Raphael has pointed to the transformative potential of sacral feminine embodiment, suggesting that, inherent in its power to create new life, is the possibility for death and disability, and pointing to the importance of temporal movement in the generative process. The stories examined in this dissertation suggest a corollary power of narrative. Because of its ability to shape and order experience, narrative has the creative potential to transform the religious or spiritual interpretation of an event.[4] And, like the generative power of feminine embodiment, the narrative process can create stories that either empower or condemn. These stories are fluid, and they can move and change over the course of a woman's life, or a provider's practice. Recall that Otto, in his description of *the mysterium tremendum* describes the possibility for an experience of grief and horror to undergo a transformation whereby it, "may be developed into something beautiful and pure and glorious." Narratives have the power to integrate experiences of the numinous during birth into the spiritual arc of a woman or provider's life, and in this way they can transform an experience of horror and grief into "something beautiful . . . and glorious."

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[3] Mircea Eliade, *The Sacred and the Profane: The Nature of Religion* (New York, NY: Harcourt Brace, 1959), 141. The beat poet, Alan Ginsberg similarly makes a connection between this experience and sex in his poem, "Song," which ends, "yes, yes, / that's what I wanted, / I always wanted, / I always wanted, / to return to the body / where I was born."

[4] Raphael, *Thealogy and embodiment*.

Appendix A: Sample Birth Plan

Labor

- I would like to be free to walk around during labor.
- I wish to be able to move around and change position at will throughout labor.
- I would like to be able to have fluids by mouth throughout the first stage of labor.
- I will be bringing my own music to play during labor.
- I would like the environment to be kept as quiet as possible.
- I would like the lights in the room to be kept low during my labor.
- I would prefer to keep the number of vaginal exams to a minimum.
- I do not want an IV unless I become dehydrated.
- I would like to wear contact lenses or glasses at all times when conscious.

Monitoring

- I do not wish to have continuous fetal monitoring unless it is required by the condition of my baby.
- I do not want an internal monitor unless my baby has shown some sign of distress.

Labor Augmentation/Induction

- I do not wish to have the amniotic membrane ruptured artificially unless signs of fetal distress require internal monitoring.
- If labor is not progressing, I would like to have the amniotic membrane ruptured before other methods are used to augment labor.
- I would prefer to be allowed to try changing position and other natural methods (walking, nipple stimulation) before Pitocin is administered.

Anesthesia/Pain Medication

- I realize that many pain medications exist. I'll ask for them if I need them.

Cesarean

- Unless absolutely necessary, I would like to avoid a Cesarean.
- If my primary care provider determines that a Cesarean delivery is indicated, I would like to obtain a second opinion from another physician if time allows.
- If a Cesarean delivery is indicated, I would like to be fully informed and to participate in the decision-making process.
- I would like my husband present at all times if my baby requires a Cesarean delivery.
- I wish to have an epidural for anesthesia.
- So I can view the birth, I would like the screen lowered just before delivery of my baby.
- If my baby is not in distress, my baby should be given to my husband immediately after birth.

Episiotomy

- I would prefer not to have an episiotomy unless absolutely required for my baby's safety.
- I am hoping to protect the perineum. I am practicing ahead of time by squatting, doing Kegel exercises and perineal massage.
- If possible, I would like to use perineal massage to help avoid the need for an episiotomy.
- I would like a local anesthetic to repair a tear or an episiotomy.

Delivery

- I would like to be allowed to choose the position in which I give birth, including squatting.
- I would like to try to deliver in a hands-and-knees position.
- I would like to try to deliver in a squatting position, using my husband or a squatting bar for support.
- I would like a mirror available so I can see my baby's head when it crowns.
- I would like the chance to touch my baby's head when it crowns.
- Even if I am fully dilated, and assuming my baby is not in distress, I would like to try to wait until I feel the urge to push before beginning the pushing phase.
- I would appreciate having the room lights turned low for the actual delivery.
- I would appreciate having the room as quiet as possible when my baby is born.
- I would like to have my baby placed on my stomach/chest immediately after delivery.

Immediately After Delivery

- I would like to have my husband cut the cord.
- I would prefer that the umbilical cord stop pulsating before it is cut.
- I would like to hold my baby while I deliver the placenta and any tissue repairs are made.
- I would like to hold my baby for at least 15 minutes before (he/she) is photographed, examined, etc.
- I would like to have my baby evaluated and bathed in my presence.
- I plan to keep my baby near me following birth and would appreciate if the evaluation of my baby can be done with my baby on my abdomen, with both of us covered by a warm blanket, unless there is an unusual situation.
- If my baby must be taken from me to receive medical treatment, my husband or some other person I designate will accompany my baby at all times.
- I would prefer to hold my baby rather than have (him/her) placed under heat lamps.
- I do not want a routine injection of Pitocin after the delivery to aid in expelling the placenta.
- I would like to delay the eye medication for my baby until a couple hours after birth.
- After the birth, I would prefer to be given a few moments of privacy to urinate on my own before being catheterized.
- I would like to see the placenta after it is delivered.

Postpartum

- Unless required for health reasons, I do not wish to be separated from my baby.
- I would like to have my baby "room in" and be with me at all times.
- I would like to have my baby "room in" after I have had some time to recover.
- I would like my baby with me during the day but in the nursery at night.

Breastfeeding

- I plan to breastfeed my baby and would like to begin nursing very shortly after birth.
- Unless medically necessary, I do not wish to have any bottles given to my baby (including glucose water or plain water).
- I do not want my baby to be given a pacifier.
- I would like to meet with a lactation consultant.

Circumcision

- I do not want my baby circumcised.

Photo/Video

- I would like to take still photographs during labor and the birth.
- I would like to make a video recording of labor and/or the birth.

Other

- My support person(s) is/are my mother and I would like them to be present during labor and/or delivery.
- I would like my other child/ren to be able to visit me and my baby in the hospital.
- I would prefer that no students, interns, residents or non-essential personnel be present during my labor or the birth.

Appendix B: Isaiah 34, NIV

The Helper of Israel

1 "Be silent before me, you islands!
Let the nations renew their strength!
Let them come forward and speak;
let us meet together at the place of judgment.
2 "Who has stirred up one from the east,
calling him in righteousness to his service[a]?
He hands nations over to him
and subdues kings before him.
He turns them to dust with his sword,
to windblown chaff with his bow.
3 He pursues them and moves on unscathed,
by a path his feet have not traveled before.
4 Who has done this and carried it through,
calling forth the generations from the beginning?
I, the LORD—with the first of them
and with the last—I am he."
5 The islands have seen it and fear;
the ends of the earth tremble.
They approach and come forward;
6 they help each other
and say to their companions, "Be strong!"
7 The metalworker encourages the goldsmith,
and the one who smooths with the hammer
spurs on the one who strikes the anvil.
One says of the welding, "It is good."
The other nails down the idol so it will not topple.
8 "But you, Israel, my servant,
Jacob, whom I have chosen,
you descendants of Abraham my friend,
9 I took you from the ends of the earth,
from its farthest corners I called you.
I said, 'You are my servant';
I have chosen you and have not rejected you.
10 So do not fear, for I am with you;
do not be dismayed, for I am your God.
I will strengthen you and help you;
I will uphold you with my righteous right hand.

11 “All who rage against you
will surely be ashamed and disgraced;
those who oppose you
will be as nothing and perish.
12 Though you search for your enemies,
you will not find them.
Those who wage war against you
will be as nothing at all.
13 For I am the LORD your God
who takes hold of your right hand
and says to you, Do not fear;
I will help you.
14 Do not be afraid, you worm Jacob,
little Israel, do not fear,
for I myself will help you,” declares the LORD,
your Redeemer, the Holy One of Israel.
15 “See, I will make you into a threshing sledge,
new and sharp, with many teeth.
You will thresh the mountains and crush them,
and reduce the hills to chaff.
16 You will winnow them, the wind will pick them up,
and a gale will blow them away.
But you will rejoice in the LORD
and glory in the Holy One of Israel.
17 “The poor and needy search for water,
but there is none;
their tongues are parched with thirst.
But I the LORD will answer them;
I, the God of Israel, will not forsake them.
18 I will make rivers flow on barren heights,
and springs within the valleys.
I will turn the desert into pools of water,
and the parched ground into springs.
19 I will put in the desert
the cedar and the acacia, the myrtle and the olive.
I will set junipers in the wasteland,
the fir and the cypress together,
20 so that people may see and know,
may consider and understand,
that the hand of the LORD has done this,
that the Holy One of Israel has created it.
21 “Present your case,” says the LORD.
“Set forth your arguments,” says Jacob’s King.

[22] “Tell us, you idols,
what is going to happen.
Tell us what the former things were,
so that we may consider them
and know their final outcome.
Or declare to us the things to come,
[23] tell us what the future holds,
so we may know that you are gods.
Do something, whether good or bad,
so that we will be dismayed and filled with fear.
[24] But you are less than nothing
and your works are utterly worthless;
whoever chooses you is detestable.
[25] “I have stirred up one from the north, and he comes—
one from the rising sun who calls on my name.
He treads on rulers as if they were mortar,
as if he were a potter treading the clay.
[26] Who told of this from the beginning, so we could know,
or beforehand, so we could say, ‘He was right’?
No one told of this,
no one foretold it,
no one heard any words from you.
[27] I was the first to tell Zion, ‘Look, here they are!’
I gave to Jerusalem a messenger of good news.
[28] I look but there is no one—
no one among the gods to give counsel,
no one to give answer when I ask them.
[29] See, they are all false!
Their deeds amount to nothing;
their images are but wind and confusion.

Appendix C: "The Grief Cycle"

DENIAL

The tourists are easily fooled
by piercing wails. The mood and brood
that split easily between tears and inane laughter.
The Tourists look for white capped waves,
pounding surf and pain shifting like dunes.
They are distracted by the drama.
The show and tale.

Those immigrants who dwell here
know that this is a country of held breaths.
Grief lives in the lungs, in the frozen swell
of the chest. The dry breasts. Immobile,
unmoving death hosts a quiet table after all, and
silence is the soft, expensive spell
that prevents our deportation,
We aliens who linger.
We, the bereft.

ANGER

When I was giving birth to you
I ordered my mother and the midwife to smile.
This is still a birth I growled,
no mourning till afterward.
They were kneeling around me
with their arms open in supplication.
They were praying.
They were holding me up.
They were waiting for me to fall.
My mother's face swam and bobbed, bloated with fear
her wide eyes tracing the veins of your death
under my skin. Laughter tricked down my cheeks
as I looked at her.
Please come, I said. It's okay,
we all want to meet you, I lied.
Your father and I presented a unified front.

When I was giving birth to you
the hospital nurses kept putting me back in bed.
They inserted the drug to cause contractions
into my cervix and told me to lie still.
We watched movies and played cards.
We told jokes and played the radio.
Your father was talking about work.
We told more jokes.
One made you father laugh so hard that he excitedly
started to explain the babysitting arrangement,
the words expanding and clinging to him in a yellow fog.
They ate through his skin
and left the smell of ashes in his hair.
He suffocated, right there in the hospital.

When I was giving birth to you
the midwife said "see the window opening;"
"soft and open" she said.
I threw my arms wide and moaned.
I squatted and leaned on your father.
He was a throne, an anchor, a windowsill.
The midwife pulled her bloody hand
from my cunt and said the cervix is tilted back

“Think loose and forward,” she said,
“loose and forward, soft and open.”

When I was giving birth to you
I saw you at the bar you would never sit at
smoking the cigarettes that were too late to kill you.
Pulling up your skirt and laughing with
your tongue between your teeth.
Come on you harlot, I said, you tease.
Heartbreaker. Rebel. Live fast
and die young. Come out, I thought,
and show us your exquisite corpse.

When I was giving birth to you,
you, who could never be born.

BARGAINING

Susan flinched as the heavy doors whined and thudded shut behind her. These luncheons were bad enough without having to make an entrance, particularly a late entrance. She skimmed through the room with as light a touch as possible, hanging to the paneled walls. Bethany, her senior partner, a dark haired severe looking woman, was holding a seat for her. She poured herself into the chair, trying to be absolutely invisible.

Bethany looked casually around the room, "What did the Doctor say?" she asked.

Susan inhaled and cocked her head jauntily, "He says I'm doing fine" she replied. "He gave me permission to start walking or doing yoga. I can't wait to start loosing the weight. He said I'll have to wait the full 6 weeks before I do anything high impact."

Bethany snorted "Doctors!" she exclaimed in her deep, ripe voice. "They always tell you not to do anything but lie down and stare at the ceiling, then they wonder why you get depressed." She slapped the table claiming a paper napkin and wrote down a phone #. "This is my personal trainer" Bethany said sliding the napkin to Susan, "call him. He'll get your endorphins up."

"Thank you" Susan said blandly. A waiter brought Susan a plate of forgettable chicken and a white wine. He put her glass down squarely on the scribbled napkin.

The audience broke into a scattering of applause, and the panel was opened up for questions. The luncheon was mostly for the Senator. The panel had been filled out with middle-aged women the association tagged as "Pathfinders!" "Trailblazers!" "Pioneers!". At events like this Bethany always called them "shoop girls." Susan thought that was a bit tacky.

On the other hand, "Trailblazers!" had never appealed to her either. Once, at a staff meeting, Bethany had said a trailblazer was just a "machete wielding bitch." She

looked right at the group of new associates and said “Don’t think any of those women at the top did it for you. Don’t think any of us are your friends. It will be your own fighting and sacrificing that’s going to get you ahead.”

Susan looked at the assembled group of women and suits. She would bet that not three had intended to be lawyers, and that all of them had fallen into careers, slipped down the razor’s edge of that first big job. Perhaps though she was just getting cynical. A few months ago she was too young to be cynical.

A soft bodied red-headed woman at the next table stood up. She introduced her self as the past Women Lawyer’s Association president and went through the general niceties of thanking the speakers and complementing their impressive resumes. Then she stopped speaking, wringing her hands slightly. Susan noticed that her sleeves seemed just a bit long. “I guess if I have a question” the red-head said “it’s just, you know how did you manage it all, careers and children, etc.” She seemed slightly embarrassed and sat down.

The panel members all nodded knowingly, their faces full of empathy. The Senator went first. “I don’t have any children myself” she said “but I understand your concerns, these are questions that affect us all, its just a matter of setting priorities and being flexible. . .” She droned on with all the Oprah Winfrey platitudes. The shoop girls, the corporate spokesmodel, the dutiful prosecutor, dry scholar, all said basically the same thing “I don’t have children but–“. The public interest lawyer seemed almost sheepish when she admitted to having kids. She was a plain woman, in a plain suit, but her lapel was covered in femo faces and dollhouses, the bright primary colored pins sold by children’s charities. “I had a house husband,” she explained. “He’s a musician.” Bethany rolled her eyes at it all. “This event is a wealth of practical information,” she said.

Bethany.

Susan found herself relying on the senior partner's bitter humor. Bethany had taken her out drinking the day she found out there was no heartbeat. Susan hadn't told her, and she never asked how Bethany found out. Honestly she didn't care, she'd just been grateful to get out of the office, to drown mojitos while John slowly extracted himself from work and came to pick her up. She'd wanted to avoid everything.

A scattering of other questions was asked, before the new WLA president clumsily closed the floor. Susan gathered up her purse and started toward the door, but Bethany took her elbow. "We're going this way," she said. "That over there is Dr. Stevens. She and her husband owned a very successful medical research practice. Now however they are getting divorced and I don't think that she has a counsel yet."

They went over to Dr. Stevens, she was standing with the red-headed woman who'd asked about children. "I'm so surprised that no one on the panel had children" the Dr. Stevens said "I've been to a hundred of these things and I don't think its ever happened before."

The red headed woman gave shallow smile "Tells you something, though doesn't it" she said.

"It will work out Judy," Dr. Stevens said, "it just does. Everything always comes out for the best."

"I couldn't agree more Sarah," Bethany said sliding into the conversation. The two women hugged each other. "I heard about Todd" Bethany said, lowering her voice and leaning conspiratorially forward. The two women were quickly involved in a quiet and furious conversation.

Susan smiled at the red head. "I'm Susan," she said holding out her hand, "*Akin Gump*."

"Mary, *Bracewell and Patterson* – for now at least" the red-head responded giving a wry smile. She had a firm handshake, dry and decisive.

There was an awkward moment of silence.

"How many children do you have?" Susan asked.

"Two" said Mary, "both girls, 2 and 5. And you? Do you have any kids?"

Susan shook her head. "No," she said. It was true after all, and who really wanted to hear more. It just put them on the spot, gibbering "I'm so sorry," and "that's just terrible." There was variety, the head of the compensation committee had leveled his icy eyes at her and said "At least you weren't on fertility drugs for 9 years." Then he'd sighed and shaken his head and given her the best evaluation she'd ever had. The girls in secretarial had showered her with cards; everyone from Deepak Chopra to Joel Osteen asserting that order still existed in the universe. Tears would well up in the eyes of her secretary, then she would urge, plead with Susan not to give up, to try again.

"Susan" Bethany called. "Come over here and meet my dear friend Dr. Sarah Stevens."

Susan smiled at the red-head, Mary of Bracewell and Patterson, for now at least.. Her cheeks felt stiff against the bones of her skull. "I have to go," Susan said, knowing that somehow, imperceptibly, her mouth wasn't moving right.

"Of course," Mary said. "It was very nice to meet you"

"You too" said Susan as she walked away.

DEPRESSION

Today is Monday and I have my period.
Months ago they told me that labor pains
were like menstrual pains, but more.
The thighs pushing on the lower back,
the lower back pulling on the abdomen,
the abdomen squeezing the womb,
the womb uncoiling its constrictions,
until life floods into the world.

Yesterday was Sunday. My husband and I
lay in bed all morning. We made love
with gentle determination until the cramps
started in my back and I cried out.
and rolled away shuddering. Later,
he held me in the shower, letting the hot water
roll down my back. "I can hold you up," he said.
I pressed my face to his chest
and listened to the rasping sighs in his skin.
I felt the air creak as he braced himself
against the void, the endless griefs past.

Saturday night his head was pressed to my bosom.
He suckled at my breast and drew the
the hands of pain out of my chest,
They filled his mouth with dry sobs
that could not escape, the sadness climbed
through my ears and out my mouth, until
he touched my cheeks and I leaned
against the distant reach of his hand
opening my eyes to watch the darkness
lap at his arm, soaking the pillows between us.

Friday, was the due date. I realized this in the bathroom
as I was putting away a fresh box of tampons.
It has been long enough since you died for me to have three periods.
They told me that labor pains were like menstrual pains, but more.
At the hospital though, none of the polyester rose nurses, with
their white rustling about anti-depressants
and gentle determination to keep me in bed, mentioned
that menstrual pains were like labor pains, but less.

The thighs, the back, the abdomen, the womb—and life floods.

ACCEPTANCE

January 6th we found out that the baby had no heartbeat. On January 9th we delivered a baby girl, 1 pound 7 ounces, 13 inches long. We named her Penelope Anne and had a memorial service a week later.

It is such a strange unrequited love, this passion I have for her. I didn't know her, there wasn't really any her to know. She did seem to kick harder to Beatles music than to mozart. She had the most response to John Lennon alone. Of course I don't know if this was because she liked it, or because it irritated her. For all the space we shared, the intimacy of our contact, she was unknowable; she was hidden, veiled like all spirts. My sensory processes of smell, sight, taste were useless. Even touch was crippled. I could feel her but not with my fine tuned fingers or my nerve loaded lips.

Not that there weren't sights and smells and touch; they just all came after she died. After her head had swollen with liquid trapped in it by the knotted cord; after she had been delivered without a heartbeat, without any chance of bringing her own senses to the world. She was laid in my arms, tiny, red and unfinished. Her features not fully human yet, still flattened and alien like. The skin around her skull stretched and grotesquely loose; it pooled on the blanket. She was beautiful.

She smelled of blood. The warm musky odor of the womb and vagina. It's a hard smell to describe, to capture in its complexity. Once Billy and I were at a restaurant and ordered yam cakes: little patties of yams and green onions deep fried in fish oil and served with a sweet dipping sauce. They smelled like me. Like my sex. Like my baby would smell, at least partly. That first night, still in the hospital, I woke up smelling the placenta as it moved through my body. For a moment, I would be seized by the

conviction that the nurses had taken my baby, that they were hiding her. Then I would remember that it was true. I would also remember why. I went to the bathroom and washed my self with warm water.

Last week when Billy and I made love again, last week when I pressed against his skin and pushed my nose into the little places on a body that capture scent (behind the ear, at the hairline, inside the knee), I realized that he smelled like the baby too. The smell was inside of me. It was on us both.

I have good days and bad days. I am slower, though. I have less interest in using my mind and more desire to keep my hands moving. I've been quilting. Every now and then I have a moment of panic, or weeping. I find myself holding my breath. I find myself laughing or singing. I hear how my voice has changed, how it is lower and gruffer and softer. I have less noise in me now.

Bear with me, if I write at all now, I write about Penny in one way or another.

My friend Melissa wrote me an e-mail about Latino funerals. She says they always touch the body. They take pictures of it. They take pictures of themselves posed with it. Everyone cries full force while stuffing their faces with tamales. Everyone has to touch the body.

There is so much advice available about how to handle a still-birth, if you know that its going to happen. Our midwife talked to us about it, the hospital gave us literature, all the nurses gave advice, we did a Google search. Here is the list of things to do: hold the baby, inspect it; take pictures; make footprints, hand prints, or gather locks of hair for mementos; cry.

I'm very glad we had the list. It's good advice. It's the right advice. It's harder to follow than it sounds; they put that little body in my arms, still hot from the womb, her skin peeling, her color wrong, her features unfinished, and I thought she's dead. My baby

is dead. That thought has popped into my head every half hour since. It's not passionate or terrible, it just is. I see a child and think--my baby is dead--what a cute kid. I see strollers and think—I like that pattern--my baby is dead--why is all that shit so fucking expensive. I have a twinge in my stomach and think--my baby is dead--Chinese food sounds. But the body . . .

Death is ethereal. A spark, a soul, a mystical animating force that was, is gone. It leaves the body. Dead is physical in a grimy, dirty, grand, and private way. Like sex. Or birth. Except that there is no one giving awkward, incomplete, inaccurate but earnest "this is what it's like to be dead stories." Only the body is left. It bears the marks. It is forever changed.

They put her little body in my arms, hot and barely a weighing a pound; I was embarrassed for her. The privacy of her death had been violated. She had to be looked at when she was unfinished, inanimate, less than beautiful. I didn't want to feel her cooling in my arms. I wanted to put her back into my belly, her dark private place. I wanted to send her away so that the body would stop having to be so obviously, unflattering, unflinchingly dead. So that I could stop looking for a while, and could let some other thought come into my head.

We had only ever known each other through the veil of my belly. This body was . . . so obviously not the way we were supposed to meet, yet here it was our only meeting. It was uncomfortable, a social faux. I felt like a bad hostess trying to handle a difficult guest. "You said come to the party in your Birthday suit?" she cries. "Oh my, I'm so sorry, I thought you said Dead suit! The are almost the same after all, do you think it will be alright? Will any one notice?"

I held her. We took pictures. I told them to take her away.

The nurse was asking if we had called the funeral home. She said she had to take the baby to weigh and measure her. She said she would bring the baby back and then leave us for a while. All alone, Billy, the baby and me. She wouldn't look directly at me or Billy. She fidgeted. I told her to take the baby away. She seemed relieved. She told us we could ask to have the baby back. That she would be in storage till the morning. We never asked. We both regretted that latter.

In the middle of the night I realized that Billy had never held her. He was working on the pictures trying to make one the correct color and I realized he hadn't held the baby. I asked him if he wanted to call the nurse. If he wanted to hold her. He said no, and I didn't press. I was terrified that they would bring her back. That she would be even more of a body, cold and refrigerated, or decomposing. Billy says he thought this too. Neither of us cried that night. We cried before and after, but not that night, not in the hospital, not with the nurses.

We had to sign papers for the funeral home. We were lucky to find one that would cremate an still born-infant for free. The other homes quoted us prices that seemed ridiculous, $700, $1,000. They would silently guilt us for not wanting to pay, and we would be silently guilty. The baby was dead, body had to be cared for. We had to care.

We had to sign papers for the funeral home. I realized as they sat in front of me that until I signed the body would still be there. I thought about calling the funeral home and asking to see her. I didn't. Billy drove down to drop off the papers. He realized that she would still be there as well and thought about asking to see her body. He didn't. That night he told me that when he sees a child, or a father with a baby, a forced quiet comes over him. Not numbness he says, just a strict quiet, an absolute internal stillness, a self-

imposed empty space, a breath, a pause before the next thing that has to be done. I listened to him and thought--my baby is dead--I feel like that too.

My baby is dead. I take out the pictures. I put them up on the wall. I build an altar, take it down, and build it again. I want to show the pictures. I want to surprise myself with them. I want to frame them and just have them about. Like the refrain in my head, my baby is dead. I want everyone to see. She was here. She had a birth and a death. She had a body.

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Vita

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